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ABSTRACT

This report brings together the latest available statistics to record national achievements in child survival, health, nutrition, education, family planning, and progress for women. Each section contains a commentary and a presentation of related statistics. The commentaries of the report are: (1) Introduction, "One Small Step for a Summit" (Peter Adamson); (2) Nutrition, "Millions Lost to Wrong Strategies" (Urban Jonsson); (3) Health, "A Measure and a Means of Health" (Jon Rohde); (4) Education, "Education for All Can Still Be Achieved" (Fay Chung); (5) Family Planning, "The Decisive Decade" (Margaret Catley-Carlson); (6) Progress for Women, "Change for the Last and the Least" (Gertrude Mongella); (7) Child Rights, "They Will Not Get Away With It Forever" (Stephen Lewis); and (8) The Industrialized World, "This Is Not Who We Are" (Marian Wright Edelman). The report also includes a section, "National Performance Gaps," that provides additional statistical information on the progress of nations. This section presents: the national performance gaps for all countries in child survival, child nutrition, and primary education; the annual rate of progress in extending immunization against measles; and a basic social profile of each nation with a listing of the social development goals that have been adopted for 1995 and the year 2000. (TJQ)

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THE PROGRESS OF NATIONS

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The nations of the
world ranked according
to their achievements
in child health, nutrition,
education, family
planning, and progress
for women

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THE PROGRESS OF NATIONS

The day will come
when the progress of nations will be
judged not by their military or economic
strength, nor by the splendour of
their capital cities and public buildings,
but by the well-being of their peoples:
by their levels of health, nutrition and education;
by their opportunities to earn a fair reward for their
labours; by their ability to participate in the
decisions that affect their lives; by the respect that is
shown for their civil and political liberties;
by the provision that is made for those who are
vulnerable and disadvantaged; and by
the protection that is afforded to the growing minds
and bodies of their children.
The Progress of Nations, published annually
by the United Nations Children's Fund, is a
contribution towards that day.

1994

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In recent years, increasing attention has been paid to the task of directly meeting obvious human needs, and to the evolution of new and better ways to measure and evaluate that effort.

The United Nations Development Programme has made a major contribution to this process through the publication of its annual Human Development Report, *incorporating a human development index. Important contributions have also been made by the* World Development Report, *published by the World Bank, particularly in its 1993 report, 'Investing in Health'.*

The Progress of Nations *draws on information provided by these and other members of the United Nations family, and particularly on the statistics and published studies of the World Health Organization and UNESCO. Additional data have been provided by the UNICEF field offices throughout the world, by National Committees for UNICEF, and by several international non-governmental organizations.*

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CENTRAL AMERICA and CARIBBEAN

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The Progress of Nations is published by the United Nations Children's Fund (UNICEF) as a contribution to monitoring and improving the well-being of children in all nations. Each year, it brings together the latest available statistics to record national achievements in child survival, health, nutrition, education, family planning, and progress for women.

In each of these areas, the international community has set specific goals, to be reached by 1995 and the year 2000. These targets, listed on pages 52 and 53, reflect today's new capacity to meet minimum human needs and have inspired the formal commitment of 157 governments. *The Progress of Nations* will keep track of action and achievement in the fulfilment of these commitments.

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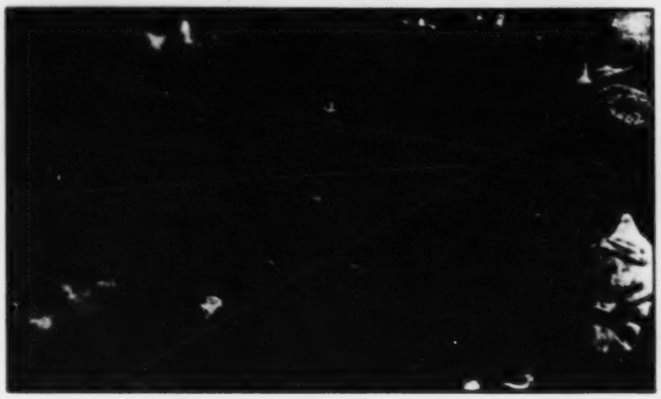

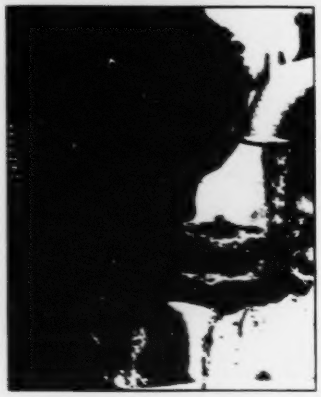

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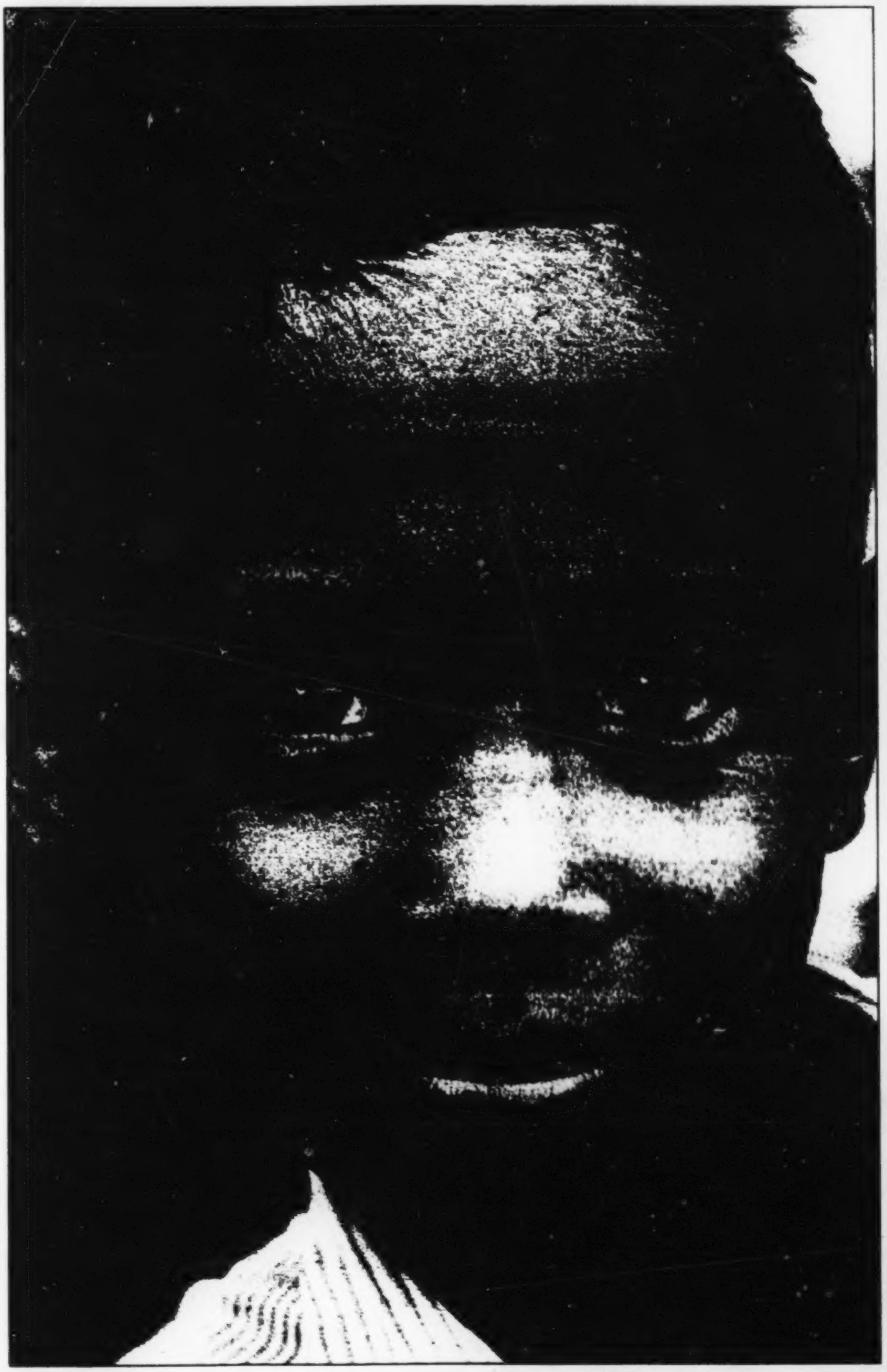
INTRODUCTION

A majority of countries now publish annual or even quarterly economic data.

But very few produce regular statistics to show what percentage of their children are malnourished, or suffer from preventable illnesses and disabilities, or have access to safe water and sanitation.

Yet it is statistics such as these that speak to real human progress.

And it is essential that social statistics should also now become the stuff of political debate, media coverage, and public concern.



One small step for a Summit

Peter Adamson

Peter Adamson is an adviser to the Executive Director of UNICEF with responsibility for preparing The State of the World's Children report and The Progress of Nations. Founder of the New Internationalist magazine, he initiated the 'State of the World' series of annual reports issued by United Nations agencies, and is the author of Facts for Life.

The Progress of Nations is a flawed publication. It uses statistics to measure and compare national achievements in social development – in health, nutrition, education, family planning, child rights, and progress for women. But its statistics are frequently out of date, incomplete, and sometimes based on extrapolations or mathematical models rather than on vital registration systems or on the systematic collection of representative data. The facts and figures assembled in these pages are the best and the latest available, but they are not nearly good enough.

Half the nations of sub-Saharan Africa, for example, have not measured their child death rates by any direct method for at least the last ten years; 15 of them are still working with data from the 1970s. In Asia, the position is marginally better, but four nations are still using under-five mortality statistics from the 1970s and only Hong Kong and Singapore have data from the 1990s. Even Brazil and Mexico – populous nations capable of great and sophisticated undertakings – have not published national figures on child deaths in the last decade.

Faith in statistics

This statistical arthritis affects almost every bone in the body of social development. Three quarters of the developing countries, for example, are still using 1980s statistics for the percentage of married couples who use family planning. Easier-to-collect statistics like the proportion of children who complete primary school tend to be more up to date, but 15 nations have still not produced any new data since 1980. And when it comes to more difficult statistics, such as the percentage of children malnourished, then we find that at least half the world's nations have no data for at least the last ten years. The average ages of key social indicators can be found on page 54.

Many of these social statistics, it is true, are regularly massaged in an effort to keep them alive, and some are permanently hooked up to life-support machines, computers which busily interpolate and extrapolate in order to produce signs of statistical life. Fresh-looking figures are therefore generated and published annually in most fields of social development, but faith in this process cannot be absolute when it leads the United Nations family to publish steadily declining under-five mortality rates for, say, Indonesia which then have to be reversed when real measurements are taken. Best estimates of Indonesia's child death rate reported a steady decline from 119 per 1000 births in 1988 to 86 per 1000 in 1991 – a fall of almost 30%; but in 1992 the figure leapt back up to 111 per 1000, as the results of new surveys became available.

A statistic like the under-five mortality rate should serve as a child-minder to governments and social policy makers, but who can trust a child-minder that loses well over 100,000 children in a single year?

Similarly, extrapolations of early 1980s trends in China's under-five mortality rate led to a widely published estimate of 27 deaths per 1000 births for 1991. When new survey data became available in 1992, it was found that the trend had not continued downward as expected, and that the actual under-five death rate had remained at over 40 per 1000. The difference between the extrapolated rate and the surveyed rate represents a difference of approximately 400,000 in the number of children dying before the age of five.

Starting with the pioneering work of William Brass, two generations of measurement specialists have developed ingenious ways of collecting essential data in societies which do not have the institutional capacity to collect cradle-to-grave social statistics. These tools are becoming widely used by, and invaluable to, programme managers. More statistics are therefore being gathered than are finding their way into national or international use. In part, this is because their often rough and ready appearance means that they are turned back by, or never presented to, the world of published statistics. But in part also, the problem is that most of the available resources are being used for the collection of economic statistics alone. Not enough effort is being made, either by national governments or by the major international organizations, to collect essential social statistics and to open up the restricted capillaries by which the statistics that do exist can more quickly enter the world of nationally and internationally available information. Even if such information were to flow more freely, the new measurement techniques need to be deployed more widely in order to provide more frequent and more comprehensive data on a wider range of social trends.

Social summit

With the widespread realization that economic statistics alone are inadequate indicators of human progress, the case for better social statistics has become more urgent.

The idea that GNP per capita is all that counts, and therefore all that needs to be counted, has been laid to rest. And many more nails for the coffin can be found in these pages. Sri Lanka and Zimbabwe both have per capita GNPs of less than $600, but both manage to provide 90% of their children with at least four years of primary school; Brazil, with a per capita GNP of almost $3000 a year, cannot boast even half that figure. In Guatemala, about 30% of children are malnourished; in Paraguay, only marginally better off, less than 5% are malnourished. Viet Nam has a per capita GNP of only $240, but a better child survival rate than Algeria, where per capita GNP is approximately seven times higher. Similarly, many of the world's poorest nations have succeeded in reaching the goal of 80% immunization coverage while several richer nations lag behind.

Last year, *The Progress of Nations* introduced the concept of the national performance gap (NPG) as an approximate measure of these discrepancies between actual and expected-for-GNP levels of social progress. NPGs for 129 countries – in child survival, nutrition, and education – are given on pages 48 and 49.

The clear lesson of these disparities is that social policies and priorities, and well-managed strategies, are critical to human progress. Social development is a goal to be pursued and measured directly, not taken for granted as an automatic by-product of economic advance.

None of this detracts from the importance of economic growth, or the need for changes in the unjust international economic system within which the developing world must earn its living. But there is today a clear consensus that development also means action to protect the vulnerable and to invest in adequate nutrition, safe water, primary health care, basic education, and family planning. Social investments of this kind are both an end and a means of progress, meeting human needs today and laying the foundations for the economic development which will help to meet human needs tomorrow.

United Nations agencies, in particular the UN Development Programme and its series of *Human Development Reports*, have done much in recent years to give birth to this consensus. And it is a consensus which will come of age at the first World Summit for Social

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> **The World Summit for Social Development could make a determined attempt to underpin the social development effort of the next few decades by helping to institute the collection of regular, reliable, and timely social statistics in the most basic areas of human progress.**

INTRODUCTION

Development in Copenhagen during 1995, the fiftieth anniversary of the United Nations.

The reason for bringing the world's Heads of State together on this issue, as the Secretary-General of the United Nations has stressed, is that social development "goes far wider than the mandates of social ministries. It lies at the heart of economic development, of human rights, and of peace and security."

But if a major effort is now to be made to move social development to centre stage, and to spotlight the strategies which can most efficiently translate economic resources into real human progress, then there is a clear need for better social statistics to accompany that effort.

Amid the many important issues on the agenda in Copenhagen, the Summit should therefore make a determined attempt to underpin the social development effort of the next few decades by helping to institute the collection of regular, reliable, and timely social statistics in the most basic areas of human progress.

Small price to pay

In the past, the weakness of social statistics could be put down, almost entirely, to poverty and underdevelopment: it is not easy to collect data in countries where births, marriages, and deaths are not routinely registered, and individual health and education records are haphazard or non-existent. But as the years go by, inadequate infrastructure is receding as a reason and emerging as an excuse. A majority of countries now publish annual, even quarterly, data on GNP growth, inflation, unemployment, manufacturing output, and the balance of payments. More and more nations are also regularly providing information on everything from energy use to television viewing figures. Yet very few produce statistics even every five years to show what percentage of their children are malnourished, or suffer from preventable illnesses and disabilities, or have access to safe water and sanitation, or on what proportion of women receive antenatal care, or die in childbirth, or have low-birth-weight babies.

It is statistics such as these that speak to real human progress. And it is statistics such as these that need to be collected every two or three years if the commitment to social development is to be taken seriously.

The overall cost of collecting such statistics might be in the region of $10 million a year – a small price to pay for information which is essential for the efficient allocation of hundreds of billions of dollars of public resources. It is an old adage, and a true one, that if you want to change something, then first measure it.

Accountability

Improved social statistics are needed, in the first instance, by governments. They are an indispensable management tool for any government committed to extracting maximum social development mileage from every economic gallon.

But in the world's growing number of democracies, timely social statistics are also needed by opposition parties, by the media, by academic institutions, by non-governmental organizations, and by the public at large. Accountability is at the heart of democracy. And the collection and dissemination of up-to-date information on progress and problems in complex modern societies is essential to that accountability. If democracy and social development are to reinforce each other, then social statistics should become a part of the mainstream of political and public debate. Changes in annual rates of economic growth are grist to media and political mills; changes in the proportion of children who are malnourished, or who drop out of school, or who die or become disabled from preventable illnesses, should also now become the stuff of political debate, media coverage, and public concern.

More sensitive statistics on social trends are also required by the United Nations agencies, by aid ministries in the industrialized nations, and by non-governmental organizations. If mounting debt in the developing world causes child malnutrition to rise, then at least the world ought to know about it. If economic adjustment policies are causing schools and health clinics to be shut down, as undoubtedly happened in several countries during the 1980s, then it ought not to happen quietly, without the world noticing. If the $60 billion of taxpayers' money given in aid every year is not improving the lives of the poorest, then this ought to be a matter of public knowledge and concern. UNICEF and many other organizations have tried to draw the world's attention to the real human consequences of debt and adjustment policies over the last decade. How much more effective would that message have been if those consequences had been measurable, systematically documented, rather than being suspected, guessed at, pieced together from the inadequate scraps of information that happened to be available?

First call

Because of the obvious but profound connection between the mental and physical development of children and the social and economic development of their societies, the protection that society affords to its children is the touchstone of social development. And because long-term damage can result from even short-term deprivation, social trends that directly affect children should be all the more closely monitored. Statistics such as the proportion of children who are seriously malnourished, or the percentage of infants who are immunized, should be collected and published not every three years but every year in every country.

For more than a decade, UNICEF has argued that the child's one chance to grow properly in mind and body should be shielded from the mistakes, misfortunes and malignancies of the adult world, and that this protection should have a first call on society's concerns and capacities so that it can be maintained in bad times as well as good. Whether a child has health care, whether a child is immunized, whether a child grows normally, whether a child has a school to go to, should not be contingent upon the vagaries of adult society, on the rise or fall of commodity prices or debt ratios, on export levels or interest rates, or on whether or not a particular political party is in power.

This principle of 'first call for children' is the great ideal at the heart of social development. But it is a principle which cannot be upheld without strong statistical support. For in addition to doing everything possible to ensure that children are the last to suffer from economic or other setbacks, it is also essential to know how well or how badly policies to protect children are working. It is not good enough to discover five or six years later, when the statistics become available, that malnutrition rose sharply when food subsidies were withdrawn during a structural adjustment programme, or that immunization levels fell sharply during a period of acute foreign exchange shortages.

Accepted goals

Better and more current social statistics would also help to achieve the social development goals that have already been accepted by the great majority of the world's nations.

In a perfect world, the contriving of goals and targets might be unnecessary. But in the real world, goals have repeatedly proved their value: they provide benchmarks for management by objectives; they are a unifying and enthusing force for the many different people and organizations involved; they serve as a rallying point for public and media awareness; and they help to ensure that political promises are not forgotten. Vaccines would not now be preventing 3 million child deaths a year had it not been for the setting of the 80% immunization goal. And without the goal of universal salt iodization by 1995, it is very doubtful whether the world would now be making such substantial progress towards eliminating the iodine deficiency disorders which are the world's major cause of preventable mental retardation (pages 8 and 9).

The social development goals that have been accepted for the years 1995 and 2000 are set out on pages 52 and 53. But the value of such targets, and their capacity to galvanize and guide all those who participate in their achievement, is diluted by the lack of timely social statistics that tell the story of how far the effort has come and how far there is still to go.

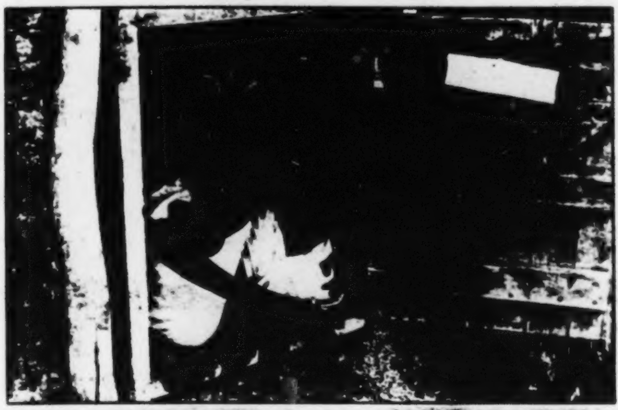
The 1995 World Summit for Social Development is therefore an opportunity not only to make a new commitment to the great social development goals that have been agreed by almost all the world's governments, but also to begin the practical work of more closely monitoring progress towards them.

Disparity

Finally, if a new effort is to be made to monitor social development, then it is important to stress that social statistics will increasingly need to be disaggregated. Even though most social indicators are not as susceptible to distortion by extreme inequalities as GNP per capita, national averages often mask deep disparities between urban and rural, between different ethnic or cultural groups, between men and women, and especially between different economic strata of society.

As the monitoring of social development gathers pace, it should therefore become more sensitive to inequality, focusing more and more on those who are being excluded – identifying who they are, where they are, and why they are being marginalized. In this way, social monitoring can also serve one of the greatest tasks of social development – the task of reaching out to the unreached and the unserved, to the illiterate and the unconfident, to the socially and culturally discriminated against, to the poorest and the most disadvantaged, to the girls and the women.

The World Summit for Social Development sets out to promote a style of development that will enable the poor majority to share in the decisions that affect their lives and to meet their own and their families' needs for adequate nutrition, safe water, primary health care, basic education, and family planning. If the Summit fails to take the small but practical step of strengthening the capacity to measure these different facets of real human progress, then it will have lost an important opportunity to introduce more efficiency and accountability into the policies and the promises. Copenhagen 1995 is a good place and time to change a style of development which has for too long regarded the poor as statistically insignificant. ☐



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Zimbabwe – child death rates down only to rise again?

850,000 extra child deaths by year 2010?

The spread of the AIDS virus is a major unknown factor in predicting social trends, particularly as they affect children.

In 1994, the United States Bureau of the Census published estimates of the impact of the epidemic on long-term population growth in the 13 African countries likely to be the worst affected. As part of this study, the Bureau projected the likely impact of HIV on under-five mortality rates up to the year 2010. The same estimates were also made for three other countries with available data - Brazil, Haiti and Thailand.

It is important to stress that the figures reproduced below are only estimates, and that they assume that future efforts to contain the spread of AIDS will be no more effective than the efforts made to date.

Estimated toll of AIDS on children by 2010

	Under-five mortality rate in the year 2010 (per 1000 births)		Number of under-five deaths in the year 2010		
	Without AIDS	With AIDS	Without AIDS	With AIDS	Difference
Tanzania	96	165	184,000	317,000	133,000
Uganda	92	184	117,000	235,000	118,000
Kenya	56	123	85,000	187,000	102,000
Zaire	97	119	266,000	327,000	61,000
Zambia	56	160	31,000	87,000	56,000
Malawi	136	209	98,000	150,000	52,000
Rwanda	89	171	51,000	99,000	48,000
Burkina Faso	109	175	66,000	106,000	40,000
Zimbabwe	38	108	20,000	56,000	36,000
Côte d'Ivoire	78	107	80,000	110,000	30,000
Burundi	79	140	27,000	48,000	21,000
C. African Rep.	118	194	22,000	36,000	14,000
Congo	97	148	14,000	22,000	8,000
Thailand	21	103	21,000	105,000	84,000
Brazil	33	44	113,000	151,000	38,000
Haiti	128	151	39,000	46,000	7,000
Totals			1,234,000	2,082,000	848,000

SOURCE US Bureau of the Census, *World population profile 1994*

NUTRITION

COMMENTARY

These pages record the progress of nations against basic nutritional problems.

One third of the developing world's children suffer from protein-energy malnutrition.

An estimated 250,000 children a year lose their eyesight because they lack vitamin A.

At least 50 million children have impaired development because they lack iodine.

Over half the pregnant women in the developing world suffer iron-deficiency anaemia.

Millions of infants are exposed to illness, poor growth, and early death by the decline in breastfeeding.

Millions lost to wrong strategies

Urban Jonsson

As UNICEF Representative in Tanzania, Urban Jonsson was closely involved in the Iringa programme which has become internationally known for its successes in reducing malnutrition on a large scale and at a low cost. From 1989 to 1994, he served as chief adviser to UNICEF on nutritional issues. In 1994, he took up his present position as UNICEF Regional Director for South Asia.

The last five years have witnessed a significant change in our perception of the malnutrition issue. And with changed perception has come new hope that the problem can be overcome more rapidly than was previously thought.

Approximately a third of the developing world's children are underweight. Most of that malnutrition is invisible – though it undermines the development of people and nations.

For many years, it was widely believed that the causes of poor nutrition could only be eradicated by gradual economic development and that, in the meantime, the only thing to be done was to treat the worst symptoms by feeding programmes of various kinds.

Both of these assumptions can now be seen to have been wrong. And I would like to stress that this is good news. For with today's understanding of the problem, every country is capable of tackling not just the symptoms but also the causes of malnutrition. It is simply not necessary to wait for 30 or 40 or 50 years for economic growth to bring about reasonable standards of nutrition. It can be done in this decade. And it can be done at a cost that, in many countries, will be little more than is currently being spent.

Learning from success

Several nations and regions are known to have reduced malnutrition while per capita incomes were still at a very low level, and countries such as Tanzania and Zimbabwe have confirmed this in recent years.

More important, we also now have a reasonably detailed knowledge of *how* to bring about this breakthrough. From the analysis of recent successes – whether in Iringa province in Tanzania or Tamil Nadu state in India – there is now considerable consensus on the 'success factors'. The challenge now is to invest resources in what we have learned, rather than continuing to pour money into approaches which at best are much less efficient and at worst simply wasteful.

The foundation of successful efforts to defeat malnutrition is a wide understanding – among government ministries, planners, health services, and the public – of the true nature of the problem. In particular, we must leave behind the notion that nutrition is simply a matter of food.

Except in famines or other emergencies, lack of food in the home is not usually the reason for a child becoming malnourished; a young child's food requirements are so small that the diversion of even a very small percentage of available food is usually enough for a child to grow properly.

Two other factors cast a darker shadow over a child's prospects for normal growth.

The first is illness. All illnesses are a threat to nutritional health: they depress the appetite; they reduce the body's ability to absorb the food that is eaten; they burn calories; they drain nutrients in vomiting and diarrhoea. And it is the sheer frequency of illness in the world's poor countries which is the single most important cause of child malnutrition.

In practice, of course, malnutrition does not have a single cause. And the second major factor is the overall quality of child care and, in particular, child feeding practices. If it is not known that bottle-feeding is vastly inferior to breastfeeding, that the family's normal food should be enriched with small amounts of oil or fats, that a child needs to eat small meals frequently, and that a special effort should be made to feed a child during and immediately after an illness – then it is very likely that a child will become malnourished even if adequate food is available in the home.

Defeating malnutrition therefore depends on three basic factors – adequate food, the prevention and control of disease, and the well-informed care and feeding of young children.

Billions wasted

It should therefore be clear that any large-scale strategy to defeat malnutrition, including improved feeding practices and the prevention and proper treatment of illness, can only be implemented and monitored on a significant scale by parents and communities. It follows that those parents and communities should be seen as active participants in the wide range of actions necessary to defeat malnutrition, and not just as passive recipients of food or services. It also means that available government resources should be focused on the poorest regions, and on the poorest people within regions, and on strategies which address not only food availability but improved health and improved child care practices. Awareness and assessment of the real problems, analysis of the real causes, and evaluation of the results – these are the essential steps; and they can only be taken by well-informed, well-supported parents and communities.

But still, today, many tens of billions of dollars are being spent – by governments, aid programmes and international institutions – on nutrition programmes that are essentially feeding programmes. Such efforts are based on a wrong analysis of the problem, and are therefore failing to bring about a solution. More intelligent strategies could multiply the impact of existing resources many times over – and with a relatively small increase in the resources available, the nutrition problem could be significantly reduced in almost every country in the years immediately ahead.

Malnutrition deaths

Finally, recent research has also made significant new contributions to our understanding of the relationship between malnutrition and child mortality. Briefly, about 55% of the 13 million under-five deaths in the world each year are the deaths of children who were malnourished. And of those 7 million nutrition-related deaths, some 80% are the deaths of children who were only mildly or moderately malnourished.

The relationship between nutritional targets and the other goals that have been adopted for the year 2000 is therefore powerfully synergistic: defeating malnutrition would accelerate progress towards the goals of improved child health and reduced child deaths; conversely, advances in the fields of immunization, ORT use, safe water supply, and basic education would accelerate progress towards the goal of reducing child malnutrition.

The following pages look at the progress being made against several specific nutritional problems that should have been banished long ago but which are now, finally, beginning to give ground. The first story on page 10 looks at national records in reducing overall protein-energy malnutrition; and it is important to remember that this is affected not only by action to increase the availability of food but also by the kinds of action recorded in almost all the other chapters of *The Progress of Nations* – health, education, family planning, and progress for women.

NUTRITION

LEAGUE TABLE OF

Lack of iodine in the diet is a major nutritional problem. It affects the normal development of approximately 50 million children, and causes an estimated 100,000 infants a year to be born as cretins. In total, 1.6 billion people are at risk – with consequences ranging from goitre to reduced mental and physical performance.

Yet the solution – iodizing all salt supplies – has been available for decades.

These pages list all nations according to the efforts they are making to overcome the problem by reaching the internationally agreed goal of iodizing all salt supplies by 1995.

SUB-SAHARAN AFRICA

Cameroon	1
Kenya	1
Nigeria	1
Rwanda	1
Botswana	2
Eritrea	2
Ethiopia	2
Madagascar	2
Namibia	2
Tanzania	2
Zimbabwe	2
Burkina Faso	3
Burundi	3
Côte d'Ivoire	3
Ghana	3
Guinea	3
Guinea-Bissau	3
Lesotho	3
Malawi	3
Mali	3
Senegal	3
Sierra Leone	3
Uganda	3
Angola	4
Benin	4
Central African Rep.	4
Chad	4
Congo	4
Liberia	4
Mozambique	4
Niger	4
Somalia	4
South Africa	4
Togo	4
Zaire	4
Zambia	4
Gabon	NO IDD
Mauritania	NO IDD
Mauritius	NO IDD

MIDDLE EAST and NORTH AFRICA

Algeria	1
Libya	1
Syria	2
Egypt	3
Iran	3
Iraq	3
Morocco	3
Sudan	3
Jordan	4
Lebanon	4
Tunisia	4
Turkey	4
Yemen	4
Kuwait	NO IDD
Oman	NO IDD
Saudi Arabia	NO IDD
U. Arab Emirates	NO IDD

SOUTH ASIA

Bhutan	1
Bangladesh	2
India	2
Nepal	2
Pakistan	2
Sri Lanka	2
Afghanistan	4

All countries have been placed in a category from 1 to 4 depending on the efforts they are currently making to iodize salt. For an explanation of what each category means, see below.

What the rankings mean...

1 Countries in which more than 75% of edible salt is fortified with iodine. In these countries iodine deficiency has already been virtually eliminated, or is expected to be virtually eliminated by 1995.

2 Countries making major efforts to fortify edible salt with iodine. In these countries most food-grade salt is expected to be iodized during the next year.

3 Countries that are planning to eliminate iodine deficiency through salt iodization but have not implemented their plans in a major way.

4 Countries in which iodine deficiency is known to be, or likely to be, a public health problem* but which do not have national plans to iodize all food-grade salt.

NO IDD Countries in which it is known, or expected, that iodine deficiency disorders (IDD) are not a public health problem. This group includes nations where adequate iodine intakes are obtained without the use of iodized salt (for example, from seafood or processed foods).

---

* IDD is defined as a public health problem when 5% or more of schoolchildren have an enlarged thyroid gland (though not necessarily visible) or low levels of iodine in urine.

SALT IODIZATION

EAST ASIA and PACIFIC

China	2
Lao Rep.	2
Thailand	2
Indonesia	3
Malaysia	3
Mongolia	3
Myanmar	3
Philippines	3
Viet Nam	3
Cambodia	4
Korea, Dem.	4
Papua New Guinea	4
Hong Kong	NO IDD
Korea, Rep.	NO IDD
Singapore	NO IDD

CENTRAL AMERICA and CARIBBEAN

Costa Rica	1
Honduras	1
Jamaica	1
Nicaragua	1
Panama	1
Dominican Rep.	2
El Salvador	2
Guatemala	2
Mexico	2
Cuba	3
Haiti	4
Trinidad/Tobago	NO IDD

SOUTH AMERICA

Argentina	1
Bolivia	1
Brazil	1
Chile	1
Ecuador	1
Peru	1
Uruguay	1
Venezuela	1
Colombia	2
Paraguay	3

The risk of iodine deficiency is reappearing in several of the former republics of the Soviet Union, including the Caucasus, Siberia, Central Asia, and the middle reaches of the Volga. IDD had been reduced to very low levels in these regions by the 1970s, but many areas at risk are now no longer receiving supplies of iodized salt. Monitoring systems have also broken down and no accurate statistics are available. UNICEF, WHO, and the International Council for the Control of Iodine Deficiency Disorders are currently working with the governments of several former Soviet republics to reintroduce universal salt iodization.

INDUSTRIALIZED COUNTRIES

Austria	1
Canada	1
Czech Rep.	1
Finland	1
Slovakia	1
Switzerland	1
Bulgaria	2
Hungary	2
Poland	2
Romania	2
France	3
Albania	4
Germany	4
Greece	4
Italy	4
Portugal	4
Spain	4
Australia	NO IDD
Belgium	NO IDD
Denmark	NO IDD
Ireland	NO IDD
Israel	NO IDD
Japan	NO IDD
Netherlands	NO IDD
New Zealand	NO IDD
Norway	NO IDD
Sweden	NO IDD
United Kingdom	NO IDD
United States	NO IDD

TARGETS

1995: Universal salt iodization in affected countries.

2000: Virtual elimination of iodine deficiency disorders.

FOR 1995 AND 2000

Momentum builds to end IDD

Iodine deficiency disorders (IDD) affect the well-being and capacities of at least 600 million people. The effect on children is particularly severe – causing physical and developmental problems and reducing IQs by as much as 10-15 points. Because of its impact on human development, iodine deficiency also has implications for social and economic progress.

The problem can be prevented – relatively easily and cheaply – by the iodization of all salt supplies.

The movement to end this problem is now gathering momentum in most parts of the developing world.

In the last five years, over half a billion people in 12 of the most seriously affected countries have begun using iodized salt. As a result, an estimated 120 million children have been spared the risk of physical and mental impairment. And there is a real chance that the 1995 goal of iodizing virtually all salt supplies will be met.

The most readily available measure of IDD is the prevalence of goitre – the swelling of the thyroid gland. The table shows the current position in the 12 most seriously affected countries.

60% of goitre in 12 countries

	Population with goitre (millions) 1992	% of households using iodized salt 1993
Brazil	21.7	95
Nigeria	11.6	90
Iran	18.5	70
Mexico	13.2	70
India	79.0	50
China	109.3	40
Indonesia	53.0	40
Tanzania	10.3	35
Bangladesh	13.5	20
Pakistan	40.4	15
Viet Nam	13.9	10
Ethiopia	11.6	0

SOURCES Salt consumption: UNICEF field offices, 1994. Goitre: WHO, *Global prevalence of iodine deficiency disorders*, WHO, UNICEF and ICCIDD, 1993.

ACHIEVEMENT AN

24 developing nations have already reduced child malnutrition to 10% or less.

30 out of 61 nations for which information is available are on track to achieve the goal of a 20% reduction in child malnutrition by 1995.

17 countries are engaged in action on a national scale to defeat vitamin A deficiency – a major cause of blindness and child deaths.

144 nations – both industrialized and developing – are supporting breastfeeding by promoting the 'baby-friendly hospital initiative'.

Tanzania – on target to meet 1995 nutrition goal

30 nations now likely to reach mid-decade goal

Recent information from 61 developing countries suggests that almost half are likely to reach the goal of a 20% reduction in child malnutrition by 1995. The goal, agreed to by almost all nations following the 1990 World Summit for Children, is part of a longer-term attempt to halve child malnutrition in the developing world by the year 2000.

Statistics on the number of malnourished children – as measured by the percentage of preschoolers who are underweight – are generally weak. But information has become available in 1994 which makes it possible to compile the following progress report for countries that are home to almost 90% of the developing world's children.

Malnutrition being beaten

Countries where less than 10% of children are malnourished

Algeria
Argentina
Barbados
Brazil
Chile
Colombia
Costa Rica
Cuba
Dominican Rep
Egypt
Jamaica
Jordan
Korea, Rep.
Kuwait
Libya
Malaysia
Morocco
Paraguay
Swaziland
Trinidad/Tobago
Tunisia
Turkey
Uruguay
Venezuela

On target

Countries where more than 10% of children are malnourished but where trends indicate that the goal is likely to be met

Cape Verde
China
Tanzania
Thailand
Viet Nam
Zimbabwe

Need a boost

Effective nutrition strategies in place, but lack of resources means rate of improvement not rapid enough to meet goal

Bangladesh
Bolivia
El Salvador
Ghana
India
Indonesia
Myanmar
Nicaragua
Pakistan
Peru
Philippines
Sri Lanka

Need a strategy

No appropriate strategies – unlikely to meet goal

Ethiopia
Guyana
Kenya
Malawi
Mexico
Nepal
Nigeria
Yemen
Zambia

Need peace

Countries unlikely to meet goal because of war or internal strife

Angola
Burundi
Haiti
Lesotho
Liberia
Mozambique
Rwanda
Somalia
Sudan
Zaire

SOURCES: Updated from UNICEF, Child malnutrition: country profiles 1993, and ACC/SCN, Second report on the world nutrition situation, vol. 2, 1993

17 countries launch vitamin A programmes, 34 fail to act

One of the most important advances in medical knowledge of recent years is the discovery that even mild vitamin A deficiency can increase child deaths from common diseases by as much as 25%. But many nations have not yet begun to act, despite the fact that vitamin A deficiency also causes 250,000 children to go blind each year.

In 17 nations, large-scale programmes are under way to ensure that all children have adequate vitamin A. But in 34 other nations with vitamin A problems, no large-scale preventive action is being taken.

In Central America, vitamin A is added to sugar. In many Asian countries, capsules are provided through immunization systems. In some nations, campaigns are promoting knowledge about foods rich in vitamin A.

Action

Countries where large-scale programmes to reduce vitamin A deficiency are being implemented

Bangladesh
Brazil
Burkina Faso
El Salvador
Guatemala
Honduras
India
Indonesia
Malawi
Mali
Mauritania
Nepal
Panama
Philippines
Somalia
Tanzania
Viet Nam

No action

Countries with vitamin A problems where no large-scale programmes are currently being implemented

Angola
Benin
Burundi
Bolivia
Cambodia
Cameroon
Central African Rep
Chad
Dominican Rep
Ecuador
Ethiopia
Ghana
Haiti
Kenya
Lao Rep
Liberia
Mexico
Mozambique
Myanmar
Namibia
Niger
Nigeria
Pakistan
Peru
Rwanda
Senegal
Sierra Leone
Sri Lanka
Sudan
Togo
Uganda
Yemen
Zambia
Zimbabwe

SOURCE: UNICEF, unpublished data

DISPARITY

Uganda – better than expected

India – worse than expected

Nutrition in some nations runs ahead of economic progress

Child nutrition in several African nations is better than expected, given the level of poverty, while several large South Asian countries are performing less well than they should.

By using economic and nutritional data from all nations, it is possible to calculate the percentage of child malnutrition that can be expected for any given economic level. The difference between this expected level and the actual level represents each country's national performance gap (NPG).

A country with Uganda's economic level, for example, could be expected to have 38% of its children malnourished; in fact it has 23% – giving a national performance gap of +15. India, at a higher economic level, could be expected to have a child malnutrition rate of 30% but has an actual rate of 63%, an NPG of –33.

This approach gives a different picture from that shown on the facing page – where countries are categorized on current trends rather than absolute levels of child malnutrition.

The lists below show the best and worst NPGs for those countries with recent nutrition statistics (1989 or later). A full listing of NPGs – for child health, nutrition, and education – is given on pages 48 and 49.

Top 12

Child nutrition is significantly better than expected for GNP per capita

	Actual %	Expected %	Difference (NPG)
Uganda	23	38	+15
Tanzania	29	43	+14
Egypt	9	22	+13
Jordan	6	17	+11
Paraguay	4	15	+11
Bolivia	13	22	+9
Jamaica	7	16	+9
Morocco	9	18	+9
Dominican Rep	10	18	+8
Malawi	27	35	+8
Mongolia	12	20	+8
Sierra Leone	29	37	+8

Bottom 10

Child nutrition is significantly worse than expected for GNP per capita

	Actual %	Expected %	Difference (NPG)
Niger	36	30	–6
Nigeria	36	30	–6
Yemen	30	24	–6
Viet Nam	42	33	–9
Namibia	26	14	–12
Pakistan	40	27	–13
Philippines	34	20	–14
Mauritania	48	24	–24
Bangladesh	66	34	–32
India	63	30	–33

Sources: GNP: World Bank, World Bank atlas, relevant years. Underweight: updated from UNICEF, Child malnutrition country profiles, 1993.

900 hospitals declared 'baby-friendly'

Over 900 hospitals worldwide are now displaying the 'baby-friendly' wall plaque which means that they are following the 'ten steps to successful breastfeeding' being promoted by WHO and UNICEF.

The two organizations launched the baby-friendly hospital initiative in June 1991 in an attempt to enlist the support of hospitals the world over in encouraging breastfeeding. WHO estimates that 1 million deaths a year could be prevented if all infants were exclusively breastfed for the first few months of life. In many countries, the main influence is the example set by hospitals and maternity wards.

So far, 19 industrialized countries have set up national authorities to supervise the baby-friendly programme, and over 250 hospitals are moving to implement the 'ten steps'.

In the developing world, most governments have begun the baby-friendly campaign by selecting influential hospitals and maternity centres to pioneer the scheme. In total, nearly 14,000 maternity units in 125 countries are now involved.

Almost every country in the developing world has now banned the free or low-cost distribution of breastmilk substitutes in hospitals and maternity wards. Industrialized nations are being challenged to follow suit.

Industrialized nations

Hospitals declared baby-friendly by 1993

Sweden	20	Czech Rep	2
Japan	2	Switzerland	2
Denmark	1	Hungary	1

Developing nations

Progress to date in the 10 most populous developing nations

	Maternity units targeted to be baby-friendly by 1995	Declared baby-friendly by 1993
China	1000	207
Philippines	1600	138
Mexico	560	55
India	1000	33
Indonesia	4000	30
Pakistan	100	7
Nigeria	35	5
Brazil	100	4
Bangladesh	5	3
Viet Nam	97	5

Source: Updated from UNICEF, Nutrition Section, Baby-friendly hospital initiative: a UNICEF progress report, December 1993.

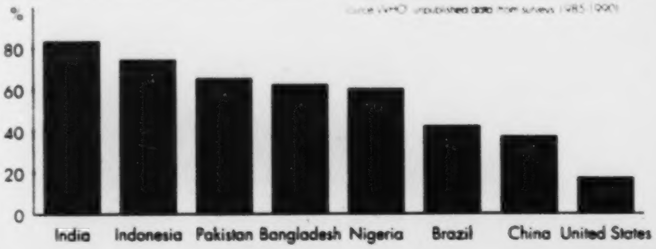
Over half pregnant women anaemic

Iron-deficiency anaemia – a major cause of death in pregnancy and childbirth – affects more than 40% of the developing world's women. If only pregnant women are counted, the proportion rises to more than 55%.

The worst-affected area is South Asia, where an estimated 60% of all women suffer anaemia (compared with 44% in sub-Saharan Africa, 26% in South America, and 13% in the industrialized nations). During pregnancy, when dietary iron requirements rise steeply, three out of four South Asian women become anaemic.

Anaemic Asia

Pregnancy anaemia rates in countries with over 3 million births a year



Source: WHO, unpublished data from surveys 1985-1990.

HEALTH

COMMENTARY

The three greatest threats to the health of children in the developing world are measles, diarrhoea, and pneumonia. Helped by poor nutrition, these three diseases kill approximately 7 million children a year and leave millions more malnourished.

Low-cost methods of preventing or treating all three – vaccine for measles, ORT for diarrhoea, and antibiotics for pneumonia – have long been available.

Immunization now reaches almost 80%, ORT almost 40%. Both are helping to build the capacity for more comprehensive health care.

A measure and a means of health

Jon Rohde

Jon Rohde is UNICEF Representative in India. As doctor, paediatrician, researcher, teacher, health service manager, and advocate, he has worked in developing countries for the last 25 years. Since 1981, he has been Health Adviser to the Executive Director of UNICEF and has played a central role in promoting immunization and oral rehydration therapy as a bridgehead for better health and nutrition for the world's children.

The rankings in this chapter of *The Progress of Nations* show the progress being made towards the goal of universalizing two specific medical interventions – immunization and oral rehydration therapy (ORT).

Overall, they tell a story of a remarkable advance. Fifteen years ago, the benefits of immunization were restricted to no more than 15% of the developing world's population; today, they are reaching almost 80%, and preventing approximately 3 million child deaths and half a million cases of polio every year.

The progress of ORT has been less spectacular, but still impressive. A little over a decade ago, this low-cost life-saving method of preventing and treating the dehydration caused by diarrhoeal disease was hardly known outside the laboratory; today it is being used by almost 40% of all families in the developing world and saving about 1 million lives each year.

After the enormous efforts that have been made, it may seem too rigorous to say that 80% immunization and 40% ORT use are not nearly enough. But the hard truth is that diseases like measles, neonatal tetanus, and diarrhoea have always been most common among the least privileged, the least well nourished, and the least served by health services. In other words, the problem is concentrated where the solutions have not yet reached. And to rest content with the successes achieved so far would be to give up with the job less than half done. Every year, 2 million children still die from vaccine-preventable disease, and another 3 million succumb to diarrhoeal disease. So while it is true that immunization and ORT have been the greatest public health success stories of the 1980s, it is also true that they remain among the greatest public health challenges of the 1990s.

Building capacity

No one would claim that immunization plus ORT equals health. But it is fair to say that progress towards the universalization of these two particular techniques is both a measure and a means of progress towards health care for all. For in their different ways, immunization and ORT require the building up of the two essential capacities, different but complementary, of a well-functioning primary health care system.

To take immunization first, universalizing the service means making a modern medical technology available to well over 120 million children on four or five separate occasions during their first year of life. It therefore requires a capacity to identify every new birth, to communicate with every new parent, and to maintain a record for every child. Clearly, a system that can achieve all this, year in, year out, has the makings of a system that can put many other technology-based medical advances at the disposal of the majority. It is in this sense that progress in immunization is both an aim and a measure not just of one particular medical intervention, but of the building up of one of the most essential capacities of any health system.

The universalization of ORT, on the other hand, demands the building up of a different kind of capacity – one which moves in the opposite direction, from the periphery towards the centre. Every family should know, for example, that a child with diarrhoea needs plenty of additional fluids, continued feeding, and an extra meal a day for a week after the illness has ended. But this advance will not on its own prevent most deaths from diarrhoeal disease. Every parent or guardian must also have somewhere to go for help if the diarrhoea seems more worrying than usual. It does not matter whether that local help point is a paramedic, or a community health worker, or a health clinic, or a doctor: what is important is that the help given should include sachets of oral rehydration salts (ORS) and correct instructions on how to use them. In the small minority of cases which are more serious still, there must be a capacity to refer the child – quickly – to a medical centre or hospital for intravenous treatment and antibiotics if needed.

It is in these senses that the ability to universalize these two specific interventions defines the essential capacities of an effective primary health system, the one starting with an essential technology and reaching out from a central point into every home, the other beginning with essential knowledge in every home and reaching inwards towards the centres of medical expertise.

Demystifying knowledge

In practice, the structures that have been strengthened and the lessons that have been learned in the attempt to universalize immunization and ORT are now beginning to contribute to better community health in several ways. India's immunization services are beginning to distribute vitamin A capsules (see page 10) and family planning supplies; safe motherhood programmes are being strengthened at monthly immunization sessions where pregnant women receive tetanus toxoid and iron tablets, are informed about possible danger signs, and are helped to know where to go, or arrange to be taken, if emergency obstetric care is needed.

The universalization of ORT helps to build a different capacity. It is not a technology that can be delivered; it must become a part of the local culture. This takes more time and patience. But the lessons and skills being learned are similar to those that are needed to demystify other kinds of medical knowledge – for example, about how to recognize and deal with pneumonia and malaria, or how to avoid AIDS. Such knowledge should become part of every family's basic stock of life-information, influencing health behaviour, and be reinforced by referral services which link more difficult health problems to more specialized health services.

Reaching out

Finally, the relevance of advances in ORT and immunization to the building of effective health services also extends to changes in the very concept of what health services are and what they do. In the struggle to achieve the goals of 80% coverage and use, many health service personnel, at all levels, have had to begin thinking of the population to be served not as those who walk through clinic doors but as the total population of a defined area. In some countries, the attempt to record the birth of every single infant in need of vaccination has begun the essential process of ordered and regular contact between health services and all families. The concepts of enumeration and accountability, of reaching out to the unreached, of working within a complex and interdependent system to achieve a common end – all of these have begun to be strengthened by the effort to universalize these two specific interventions.

LEAGUE TABLE OF

Diarrhoeal disease still kills almost 3 million children every year despite the availability of the low-cost remedy known as oral rehydration therapy (ORT).

These pages rank all countries in the developing world according to the percentage of cases of childhood diarrhoea that are treated with ORT.

Virtually unknown a decade ago, the therapy is now being used by about four out of every ten families in the developing world – and is estimated to be saving over a million young lives each year.

Almost all developing nations have adopted the goal of 80% ORT use by 1995.

SUB-SAHARAN AFRICA

		%
1	**Zambia**	90
2	**Cameroon**	84
3	**Tanzania**	83
4	**Lesotho**	78
4	**Somalia**	78
6	**Zimbabwe**	77
7	**Kenya**	69
8	**Ethiopia**	68
9	**Congo**	67
10	**Guinea**	65
11	**Botswana**	64
12	**Sierra Leone**	60
13	**Mauritania**	54
14	**Burundi**	49
15	**Angola**	48
▶	*Regional average*	*47*
16	**Benin**	45
16	**Zaire**	45
18	**Ghana**	44
19	**Mali**	41
20	**Nigeria**	35
21	**Togo**	33
22	**Mozambique**	30
22	**Uganda**	30
24	**Madagascar**	29
25	**Senegal**	27
26	**Rwanda**	26
27	**Gabon**	25
28	**Central African Rep.**	24
29	**Niger**	17
30	**Côte d'Ivoire**	16
31	**Burkina Faso**	15
31	**Chad**	15
31	**Liberia**	15
34	**Malawi**	14
35	**Guinea-Bissau**	6
	Eritrea	NO DATA
	Mauritius	NO DATA
	Namibia	NO DATA
	South Africa	NO DATA

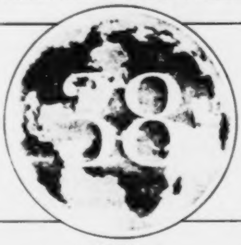
MIDDLE EAST and NORTH AFRICA

		%
1	**Syria**	95
2	**Iran**	85
3	**United Arab Emirates**	81
4	**Libya**	80
5	**Jordan**	77
6	**Iraq**	70
▶	*Regional average*	*50*
7	**Lebanon**	45
7	**Saudi Arabia**	45
9	**Egypt**	34
10	**Sudan**	28
11	**Algeria**	27
12	**Tunisia**	22
13	**Oman**	19
14	**Morocco**	13
15	**Kuwait**	10
16	**Yemen**	6
	Turkey	NO DATA

SOUTH ASIA

		%
1	**Bhutan**	85
2	**Sri Lanka**	76
3	**India**	37
▶	*Regional average*	*35*
4	**Pakistan**	34
5	**Afghanistan**	26
6	**Bangladesh**	24
7	**Nepal**	14

DEVELOPING WORLD AVERAGE



% ORT use

Fluid definition

ORT is based on the discovery that the dehydration caused by diarrhoea can be prevented and treated not by withholding food and fluids but by giving plenty of liquids – including breast-milk, gruels, soups, rice water, and even weak tea or clean water. Special oral rehydration salts are also increasingly available in pharmacies, shops and health centres. Continued feeding during the illness – and extra food in the week afterwards – is an important part of the treatment. This is ORT. And it is effective in more than 90% of cases of diarrhoeal disease.

Comparing progress in ORT is difficult because the fluids recommended vary from country to country, and the data given here are subject to some differences in definition. WHO has now revised the definition of ORT to emphasize the increased volume of fluids required when a child has diarrhoea. The definition used in these tables is the one that has been used for the last decade – 'treated with oral rehydration salts and/or appropriate household fluids'.

FURTHER INFORMATION WHO, Programme for Control of Diarrhoeal Diseases, *Interim programme report 1992*, 1993

ORT USE

EAST ASIA and PACIFIC

		%
1	**Korea, Dem.**	72
2	**Mongolia**	65
2	**Thailand**	65
4	**Viet Nam**	52
5	**Malaysia**	47
6	**Papua New Guinea**	46
7	**Indonesia**	44
8	**Lao Rep.**	30
▶	*Regional average*	29
9	**Philippines**	25
10	**China**	22
11	**Myanmar**	19
12	**Cambodia**	6
	Hong Kong*	NO DATA
	Korea, Rep.	NO DATA
	Singapore	NO DATA

CENTRAL AMERICA and CARIBBEAN

		%
1	**Cuba**	80
2	**Costa Rica**	78
3	**Honduras**	70
3	**Trinidad and Tobago**	70
5	**Mexico**	63
6	**Panama**	55
▶	*Regional average*	55
7	**El Salvador**	45
8	**Nicaragua**	40
9	**Dominican Rep.**	35
10	**Guatemala**	24
11	**Haiti**	20
12	**Jamaica**	10

SOUTH AMERICA

		%
1	**Uruguay**	96
2	**Venezuela**	80
3	**Argentina**	70
3	**Ecuador**	70
5	**Bolivia**	63
5	**Brazil**	63
▶	*Regional average*	58
7	**Paraguay**	52
8	**Colombia**	40
9	**Peru**	31
10	**Chile**	10

Regional averages are weighted for population size

INDUSTRIALIZED COUNTRIES

ORT has been slow to catch on in the industrialized nations and no statistics on its use are available. Most health services and medical schools now recommend ORT as the first-choice treatment for diarrhoea, but few parents know about it and most doctors continue to prescribe antidiarrhoeal drugs.

In the United States, where one or two children die every day from dehydration, diarrhoea accounts for 3 million visits to clinics every year and almost a quarter of a million hospital admissions. The cost of inappropriate treatment runs to more than $1 billion a year. Only 20% of American families know about ORT – half the rate in the developing world.

A recent WHO report concluded that "antidiarrhoeal drugs should never be used. None has any proven value and some are dangerous." France, Germany, the Netherlands and Norway, among others, have now banned or de-registered drugs such as loperamide.

TARGETS

1995: 80% of cases of diarrhoea in children to be treated with ORT.

2000: A halving of child deaths from diarrhoeal disease.

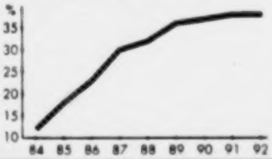
FOR 1995 AND 2000

The rise (and occasional fall) of ORT

Promoted by WHO and UNICEF for the last decade, some form of ORT has now reached approximately 40% of families.

Global estimates of ORT use

% of episodes of diarrhoea in under-fives treated with ORT (defined as oral rehydration salts and/or appropriate household fluids)



Forty nations, 16 of them in Africa, have lifted ORT use rates by 30 percentage points or more over the last seven years.

The top ten

% of episodes treated with ORT

	1986	1992	% pt. rise
Syria	9	95	86
Cameroon	1	84	83
Uruguay	21	96	75
Bhutan	11	85	74
Somalia	5	78	73
Korea, Dem.	0	72	72
Lesotho	6	78	72
United Arab Emirates	9	81	72
Tanzania	14	83	69
Libya	12	80	68

SOURCE: WHO, Programme for Control of Diarrhoeal Diseases, interim programme reports, 1988 and 1993

Several of the nations that pioneered ORT in the 1980s have since slipped back. But Bangladesh, Egypt and Mexico all have new programmes and are reporting rapid gains in 1993 and 1994.

Going down

% of episodes treated with ORT

	1986	1992	% pt. fall
Bangladesh	51	24	-27
Egypt	61	34	-27
Mexico	75	63	-12
Nepal	25	14	-11
Tunisia	27	22	-5
Myanmar	21	19	-2
Morocco	15	13	-2

ACHIEVEMENT AND

Every year, 140,000 children are crippled by polio.

A million are killed by measles.

Over 3 million die from pneumonia.

Almost 3 million succumb to dehydration.

600,000 newborns die of tetanus.

250,000 a year go blind from lack of vitamin A.

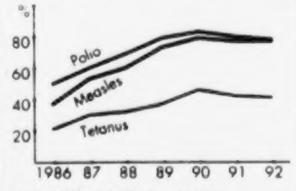
Low-cost solutions exist for all of these problems.

Progress against them is therefore a measure of a government's commitment to the health and well-being of the majority.

Tetanus immunization in pregnancy protects both mother and newborn child

Tetanus coverage falls

% of children immunized against measles and polio, and % of pregnant women immunized against tetanus, developing world, 1986-1992



Source: UNICEF and WHO, unpublished data

650,000 needless deaths

Tetanus – one of the simplest and cheapest diseases to prevent – is still killing an estimated 600,000 newborns and 50,000 mothers every year. Immunization of pregnant women against tetanus climbed only slowly to just over 45% in 1990, and has now fallen back again to just over 40%. In total, 26 countries have allowed tetanus immunization levels to fall by 10 percentage points or more in the first few years of the 1990s (see list at right).

Tetanus deaths are caused by poor hygiene during childbirth – allowing tetanus spores to come into contact with the umbilical cord. Both mother and newborn child can be protected by more hygienic births and/or by tetanus vaccine.

But while vaccines like measles and polio reach almost 80% of children, immunization of pregnant women against tetanus languishes at little more than half that level. On present trends, says WHO, the 1995 target of neonatal tetanus elimination will be missed.

Lifting coverage...

Nine countries improved tetanus coverage by 10 percentage points or more between 1990 and 1992.

	% 1990	% 1992	% pt. rise
Guinea	10	70	60
Sri Lanka	60	85	25
Viet Nam	18	42	24
Philippines	43	65	22
Myanmar	54	72	18
Morocco	64	80	16
Peru	12	27	15
Malaysia	71	83	12
Cuba	88	98	10

And letting it slide...

Twenty-six countries allowed tetanus coverage to fall by 10 percentage points or more between 1990 and 1992.

	% 1990	% 1992	% pt. fall
Madagascar	60	2	-58
Cameroon	63	7	-56
Zambia	68	20	-48
Pakistan	87	42	-45
Central African Rep	87	43	-44
Brazil	62	21	-41
Chad	42	5	-37
Ethiopia	43	7	-36
Iraq	67	32	-35
Nigeria	58	27	-31
Tanzania	42	15	-27
Mali	31	8	-23
Syria	84	63	-21
Namibia	52	33	-19
Senegal	45	26	-19
Haiti	23	5	-18
Botswana	62	46	-16
Malawi	82	66	-16
Jordan	47	32	-15
Mauritius	94	79	-15
Uganda	31	16	-15
Bhutan	63	50	-13
Côte d Ivoire	63	50	-13
Nicaragua	25	12	-13
Nepal	28	18	-10
Zimbabwe	60	50	-10

Source: WHO and UNICEF, unpublished data

Pneumonia deaths – 80% in 18 countries

Pneumonia remains the greatest single killer of the world's children – claiming the lives of an estimated 3.6 million under-fives each year.

The goal set for the year 2000 is a one-third reduction in this toll – achievable by vaccination against measles and diphtheria, parental awareness of the danger signs, and ready availability of antibiotics.

Of the 3.6 million pneumonia deaths, 80% occur in the following 18 countries.

	No. of pneumonia deaths* per 1000 under-fives 1990	Total no. of pneumonia deaths 1990
Mozambique	40	104 000
Angola	38	68 000
Mali	30	54 000
Afghanistan	29	86 000
Malawi	27	54 000
Ethiopia	17	166 000
Bangladesh	16	281 000
Tanzania	16	83 000
Uganda	16	58 000
Yemen	15	36 000
Nigeria	14	292 000
Sudan	14	61 000
Pakistan	13	277 000
Nepal	13	43 000
India	9	1 026 000
Zaire	9	65 000
Brazil	3	47 000
Indonesia	3	79 000

* Assuming a total of 3.6 million pneumonia deaths a year. This includes half a million deaths from neonatal pneumonia. If pneumonia deaths stemming from other illnesses – notably from measles and diphtheria – are added in, then the toll rises to over 4 million a year.

Sources: Pneumonia: UNICEF calculations from data in WHO Programme for Control of Acute Respiratory Infections, Interim programme report 1992, 1993. Under-five population 1990: United Nations Population Division, World population prospects, 1992.

Poorer ahead of richer

Per capita GNP below $1000, tetanus coverage 70% or more

	Per capita GNP ($) 1992	% immunized 1992
Korea, Dem.	970	96
Rwanda	250	88
Sri Lanka	540	85
Sierra Leone	170	80
Bangladesh	220	80
India	310	77
Myanmar	220	72
Guinea	510	70
Egypt	630	70

Per capita GNP $1500 or more, tetanus coverage below 50%

	Per capita GNP ($) 1992	% immunized 1992
Botswana	2790	46
Tunisia	1740	44
Iran	2190	44
Namibia	1610	33
Iraq	1500	32
Turkey	1950	22
Kuwait	16150	22
Brazil	2770	21
Algeria	1830	18

Sources: GNP: World Bank, World Bank atlas 1994, 1993. Immunization: WHO and UNICEF, unpublished data.

DISPARITY

Benin – over 50% now have safe water supply

Watering the statistics

There is no standard international definition of what is meant by access to clean water. In one country it may mean 40 litres per person per day from a standpipe within 100 metres; in another, it may mean 20 litres per person per day from a well within one kilometre. It is therefore impossible to compare the progress of nations in providing safe water.

Even dimly perceived through inadequate statistics, it can be seen that well over a billion people still lack clean water. Even more have no safe sanitation. Meanwhile, 80% of the estimated $10 billion a year spent on water supply goes to high-cost household connections for the few, rather than low-cost community water supplies for the many.

Resources are only one factor. Argentina, Gabon, Malaysia, Mexico, Oman and Uruguay all have relatively high GNPs – more than $2000 per capita – but none has managed to bring safe water to even 80% of its people.

Using their own criteria, several nations have succeeded in increasing access to safe water by more than 30 percentage points in the 1980s.

Fastest progress

	% with access to safe water 1980	% with access to safe water 1990	% pt. rise
Sri Lanka	19	60	41
Bangladesh	38	78	40
Oman	14	53	39
Burkina Faso	30	68	38
Benin	18	55	37
Lesotho	14	47	33
India	41	73	32
Zimbabwe	52	84	32
Thailand	43	74	31

Sources: 1980, UNICEF field offices and WHO; 1990, WHO, CWSSD end of decade review, 1992, and CWSSD review of decade progress, 1990. 1988 data supplied when 1990 figures unavailable.

World on track to beat polio but 22 nations let vaccine coverage fall

The world is on track towards the goal of eradicating polio by the end of the 20th century. Overall, the virus, which at its height crippled some 650,000 children a year, now claims less than 150,000 victims annually.

The last known case of polio in the western hemisphere was recorded in September 1991 in Peru. Parts of Africa, the Middle East and the Pacific are also now struggling free of the virus. Of the more than 200 nations in the world, 108 have reported no cases of polio for three consecutive years (not every case of polio is detected).

The 80% target for polio immunization was reached by some 80 countries, and many others have come close. A total of 45 countries have already reached the 90% coverage target set for the year 2000.

The main threat to polio eradication is complacency. World vaccination rates have slipped by a few percentage points since 1990, and there is evidence that the number of polio cases may also have risen slightly. In the following 22 nations, vaccine coverage has slipped by more than 10 percentage points since 1990.

Slipping

	% immunized 1990	% immunized 1992	% pt. fall
El Salvador	76	65	-11
Côte d'Ivoire	48	36	-12
Nigeria	57	45	-12
Haiti	40	27	-13
Jamaica	87	74	-13
Madagascar	46	32	-14
Togo	61	47	-14
Zambia	78	63	-15
Kenya	71	55	-16
Cameroon	54	37	-17
Ghana	56	39	-17
Lesotho	75	58	-17
Ireland	81	63	-18
Greece	96	77	-19
Senegal	66	47	-19
Sierra Leone	83	64	-19
New Zealand	90	68	-22
Botswana	82	58	-24
Dominican Rep.	90	63	-27
Brazil	93	62	-31
Ethiopia	44	13	-31
C. African Rep	82	45	-37

Bold type = zero cases reported 1990-1992

Source: WHO and UNICEF, unpublished data

Guinea worm in retreat

Guinea worm disease – which is acquired by drinking infected water and brings months of debilitating pain to its victims – has been reduced by about 80% in the last five years. Surveys in 1989 found just under 1 million confirmed cases in 16 African nations and in parts of India and Pakistan. The latest 1993 surveys have found just over 200,000.

Every nation with a guinea worm problem has now undertaken village-by-village surveys. In total, 22,000 villages have been covered. Two thirds have subsequently taken steps to break the cycle of infection.

The table shows recent progress in the most successful programmes.

Five of the best

	No. of cases found	No. of cases 1993
Nigeria	653,000 (1988)	76,000
Ghana	180,000 (1989)	18,000
India	31,000 (1985)	800
Pakistan	1,100 (1988)	2
Cameroon	871 (1989)	72

Source: WHO unpublished data

Measles ups and downs

Before a vaccine became available in the mid-1960s, measles killed approximately 7 million children a year. That toll has now been reduced to about 1 million. But measles remains the most lethal of the vaccine-preventable diseases, striking at tens of millions of children every year and leaving many of the survivors prey to malnutrition, diarrhoea, pneumonia, vitamin A deficiency, blindness and deafness.

Levels of measles immunization have on the whole remained steady following the enormous efforts made to meet the 80% target by 1990.

Eight down

	% immunized 1990	% immunized 1992	% pt. fall
Dominican Rep	96	75	-21
Austria	60	38	-22
Georgia	81	58	-23
Ethiopia	37	10	-27
Panama	99	71	-28
Togo	57	29	-28
Azerbaijan	82	50	-32
C. African Rep	82	32	-50

Seven up

	% immunized 1990	% immunized 1992	% pt. rise
Lao Rep	13	55	42
Guinea	18	52	34
Iraq	62	90	28
Bolivia	53	80	27
Trinidad/Tobago	70	93	23
Afghanistan	20	42	22
Namibia	41	63	22

Source: WHO and UNICEF, unpublished data

COMMENTARY

Almost all nations have accepted the goal of providing a primary school education for at least 80% of children by the end of the century.

In recent years, radical new approaches in some low-income countries have shown that this goal is achievable.

Of the most populous developing nations, China, Egypt, Indonesia and Mexico are on target to achieve the goal of full primary education for 80%. Brazil, and India could reach the goal with an accelerated effort. Bangladesh, Nigeria and Pakistan face a massive – but not impossible – task.

Education for all can still be achieved

Fay Chung

Fay Chung headed the drive to train many thousands of new teachers in Zimbabwe's post-independence drive to achieve education for all. After serving since 1988 as her country's Minister of Education, she was appointed in December 1993 as Chief of Education, UNICEF, New York.

Thirty years' experience has convinced me that the goal of education for all by the year 2000 can still be achieved.

In the 1960s, while teaching secondary school in what was then Southern Rhodesia, I also began teaching literacy in township night schools. But it was obvious that we needed to work on a much larger scale, and with independence on the horizon, several of us returned to universities in Africa and abroad to prepare ourselves for the challenge.

In 1980, independent Zimbabwe was born. Soon afterwards, I was appointed as first head of ZINTEC – the Zimbabwe Integrated Teacher Education Course. Our job was clear: train enough teachers so that the country could move forward rapidly towards education for all.

Bridging operation

Our choice was also clear: we could take the normal route of establishing teacher training colleges and building schools – which would have meant that two or three generations of young Zimbabweans would grow up illiterate and uneducated – or we could attempt a bridging operation in order to give those children – and their new country – the benefits of a basic education which we would then struggle to upgrade.

We had learned about unconventional approaches while working in refugee camps during Zimbabwe's war of independence. Building on this experience, and on the strategies pioneered in neighbouring Tanzania, we accepted the target of education for all within five years.

Three times a year, we recruited 900 trainee teachers for a four-month course. Instead of attempting to build large numbers of teacher training colleges, we used a combination of once-a-week meetings with tutors supplemented by distance education and on-the-job training. At the core of the programme was a carefully structured common curriculum intended to cover the basics – reading, writing, mathematics, and practical skills related to community development and improving farm productivity.

The problem of the lack of schools also yielded to non-conventional approaches. We said, 'You want a school? Then build it.' Almost all the new schools – many thousands of them just shacks with thatched roofs – were built by the pupils' own parents and communities.

The wind in our sails was the euphoria of national independence – and the pent-up demand for education that had been suppressed for so long by the white minority government. We also had the advantage of international support – especially from Sweden – which helped us to carry our plans into the most deprived areas of the country.

Within 18 months, the number of schools had risen from 1700 to 4500, and the number of primary school pupils had leapt from 800,000 to 2.3 million. Secondary schools saw a similar expansion – from 66,000 students in 173 schools in 1980 to 700,000 pupils in 1500 schools by 1985.

This is why I cannot agree that the goal of a basic education for all children by the year 2000 is a bridge too far.

Elements of success

From Zimbabwe to the Republic of Korea, from the BRAC schools in Bangladesh to the *Escuela Nueva* in Colombia, the common elements of success in expanding educational opportunities are becoming clear.

The first of those common elements has to be the effective deployment of large numbers of paraprofessional teachers. But expansion based on paraprofessionals must centre on a limited, well-thought-out course of training. And if paraprofessionals are to be retained – and to gradually improve their skills – then their abilities and qualifications should rise to the same level as more conventionally trained teachers, and this fact should be reflected in their status and their pay.

Above all, paraprofessionals must not mean poor quality. Both parents and pupils quickly recognize poor-quality education – and this is one of the main reasons behind the high rates of school drop-out in so many countries of the developing world.

Parent power

Secondly, I would say that rapid educational expansion depends on parental and community involvement. I have seen illiterate parents insisting on looking through their children's books each day. I have seen them donating cash, or bales of cotton, or long hours of labour, to get schools started and upgraded. And I have seen too that when communities are involved then standards are higher, pupils behave better, attendance rates are higher, and teachers are more accountable and more dedicated. Indeed I would go so far as to say that, in most poor countries, we will not see rapid educational expansion without parental and community involvement.

Even unconventional programmes have to be paid for. And although the ideal remains free universal education, at least up to primary level, my own conclusion is that, in most countries, school fees are going to be an essential part of a successful strategy. But I dislike the term 'cost recovery' because it implies that the government should get back the money it spends. School fees should not be returned to central government; they should remain under the control of the local community and be used for the payment of teachers and the upgrading of schools. Meanwhile, the government's own financial resources should be concentrated on overcoming the problems of the poorest – on making sure that they do not fall by the wayside in the march towards education for all.

A stable commitment

The next indispensable element is a sustained and stable government commitment. This has to be reflected in first-class educational and logistical planning and evaluation, and in high-level personnel who remain in their jobs long enough to be responsible for the plans they initiate. You cannot expect sustained progress if Ministers of Education and their senior staffs change every year, and if planning is left to expatriates on short-term contracts. Long-term dedication and seriousness of purpose are essential to the achievement of education for all.

Lastly, change is also needed in the allocation of aid. Current aid programmes do not reflect the importance of this task, nor do they support the new strategies which will be required to achieve it. At present, over 80% of aid for education goes to secondary and higher education – and more than three quarters of this finds its way back to the donors via payments for consultants and imported equipment. The time has surely now come for the industrialized nations, also, to respond to the great challenge of a basic education for all children.

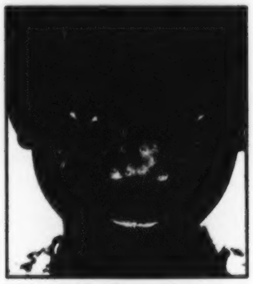
EDUCATION

LEAGUE TABLE OF

There is widespread agreement that the education of girls is one of the most important investments that any developing country can make in its own future.

In the long term, almost every other aspect of progress, from nutrition to family planning, from child health to women's rights, is profoundly affected by whether or not a nation educates its girls.

The tables on these pages therefore look at the educational progress of nations as judged by the percentage of girl children who reach at least grade 5 of primary school.



SUB-SAHARAN AFRICA

		%
1	**Zimbabwe**	93
2	**Mauritius**	91
3	**Botswana**	86
4	**Kenya**	71
5	**Cameroon**	69
6	**Congo**	68
6	**Lesotho**	68
6	**Zambia**	68
9	**Rwanda**	59
10	**Mauritania**	57
11	**Namibia**	56
12	**Ghana**	55
13	**Togo**	53
14	**Nigeria**	51
15	**Gabon**	49
16	**Côte d'Ivoire**	46
17	**Senegal**	42
18	**Burundi**	40
►	*Regional average*	*40*
19	**Madagascar**	37
20	**Zaire**	36
21	**Angola**	34
21	**Central African Rep.**	34
23	**Malawi**	26
24	**Chad**	25
25	**Benin**	24
25	**Tanzania**	24
27	**Burkina Faso**	19
28	**Mozambique**	17
29	**Niger**	16
30	**Guinea-Bissau**	15
31	**Mali**	12
32	**Guinea**	11
33	**Ethiopia**	10
34	**Somalia**	2
	Uganda	OLD DATA
	Eritrea	NO DATA
	Liberia	NO DATA
	Sierra Leone	NO DATA
	South Africa	NO DATA

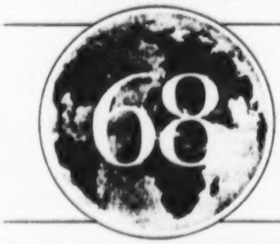
MIDDLE EAST and NORTH AFRICA

		%
1	**Turkey**	97
2	**Oman**	93
3	**Algeria**	92
3	**Syria**	92
5	**Jordan**	90
5	**United Arab Emirates**	90
7	**Iran**	89
8	**Tunisia**	87
9	**Kuwait**	83
10	**Egypt**	80
►	*Regional average*	79
11	**Yemen**	66
12	**Iraq**	63
13	**Morocco**	59
14	**Saudi Arabia**	56
15	**Sudan**	40
	Lebanon	NO DATA
	Libya	NO DATA

SOUTH ASIA

		%
1	**Sri Lanka**	95
2	**India**	58
►	*Regional average*	53
3	**Bangladesh**	45
4	**Pakistan**	28
5	**Afghanistan**	12
6	**Bhutan**	11
	Nepal	NO DATA

WORLD AVERAGE



% of girls reaching grade 5

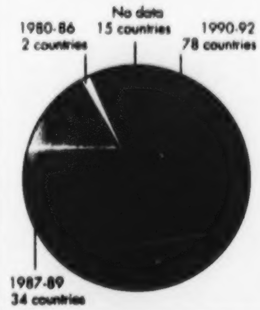
60% have data from 1990s

The data used in these tables are taken from national government statistics as reported to UNESCO. In comparison with many other social indicators, data on the percentages of children entering grade 1 and reaching grade 5 of primary school are reasonably recent and comprehensive. Such figures are, of course, no guide to the quality of the education being received.

The chart gives an overview of the recency of data on primary education.

Data dates

Latest year of data on primary school education (129 countries)



Source: UNESCO, unpublished data.

GIRLS' EDUCATION

EAST ASIA and PACIFIC

		%
1	**Hong Kong**	99
2	**Singapore**	98
3	**Korea, Rep.**	93
4	**Malaysia**	88
5	**China**	86
6	**Indonesia**	83
▶	*Regional average*	*83*
7	**Thailand**	79
8	**Philippines**	75
9	**Papua New Guinea**	60
10	**Viet Nam**	58
	Cambodia	NO DATA
	Korea, Dem.	NO DATA
	Lao Rep.	NO DATA
	Mongolia	NO DATA
	Myanmar	NO DATA

CENTRAL AMERICA and CARIBBEAN

		%
1	**Jamaica**	99
2	**Cuba**	91
3	**Costa Rica**	85
4	**Panama**	84
5	**Mexico**	80
▶	*Regional average*	*68*
6	**Trinidad and Tobago**	63
7	**Nicaragua**	46
8	**El Salvador**	45
9	**Dominican Rep.**	41
9	**Guatemala**	41
11	**Honduras**	38
12	**Haiti**	12

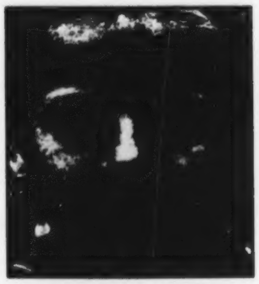
SOUTH AMERICA

		%
1	**Uruguay**	96
2	**Venezuela**	90
3	**Chile**	86
4	**Paraguay**	72
5	**Ecuador**	68
6	**Bolivia**	58
6	**Colombia**	58
▶	*Regional average*	*51*
8	**Brazil**	39
	Peru	OLD DATA
	Argentina	NO DATA

Regional averages are weighted for population size

World average excludes the nations of the former Soviet Union and former Yugoslavia

OLD DATA refers to data before 1987



INDUSTRIALIZED COUNTRIES

		%
1	**Austria**	100
1	**Finland**	100
1	**Israel**	100
1	**Japan**	100
1	**Sweden**	100
1	**Switzerland**	100
7	**Australia**	99
7	**Poland**	99
9	**Norway**	98
10	**Albania**	97
10	**Hungary**	97
10	**Spain**	97
13	**Canada**	96
13	**Czech Rep.**	96
13	**France**	96
13	**Netherlands**	96
13	**Slovakia**	96
18	**Denmark**	95
18	**New Zealand**	95
18	**Romania**	95
▶	*Group average*	*95*
21	**United States**	94
22	**Germany**	93
22	**Ireland**	93
24	**Italy**	91
25	**Greece**	90
26	**Belgium**	83
27	**Bulgaria**	78
	Portugal	NO DATA
	United Kingdom	NO DATA

TARGET

A basic education for all children and completion of primary school by at least 80% – girls as well as boys.

FOR THE YEAR 2000

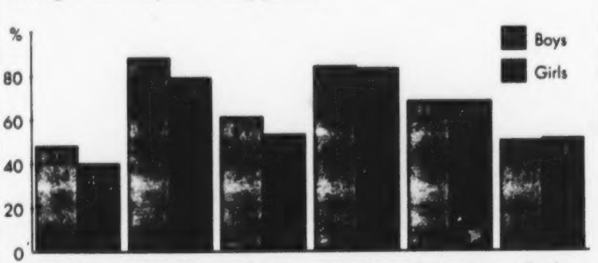
A bas la différence

The discrepancies between boys and girls in primary schooling mean that 14 million more girls than boys are out of school.

In part, this reflects the lingering view that a girl does not need an education in order to be a wife and a mother. In part, also, it reflects the real value of the work done by millions of young girls in fields and homes.

Whatever the cause, the result is exclusion and illiteracy which perpetuate the problem by depriving women of choice, status, opportunity, and confidence.

% of girls and boys reaching grade 5



The discrepancy between boys and girls in East Asian and the Pacific, and in Central America and the Caribbean may be greater than shown here as a number of countries in these two regions have no recent gender-differentiated data for the percentage of children reaching grade 5.

SOURCE UNICEF calculations from UNESCO data

ACHIEVEMENT AND

Measuring quality in education is even more difficult than measuring quantity.

Advancing literacy is one indicator. But literacy can be difficult to define, and mainly reflects educational achievement in the past.

Starting school at the right age is also important – as children learn best when lessons are geared to the right age and stage of development.

Finally, the ratio of teachers to school-age children, and the average amount spent per pupil, are also indicators of the effort being made.

Dedication required in Africa's classrooms

The class of 68

The number of pupils per teacher in the world's primary schools varies from about a dozen in Norway or Sweden to over 90 in the Central African Republic. Generally, class sizes in the developing world are at least two to three times larger than classes in industrialized nations.

Within the developing world itself, teacher-pupil ratios are not a reliable guide to the quality of education on offer. But as teachers' salaries often account for 90% of education budgets, the number of teachers is a reasonably good guide to a nation's expenditures on education (often difficult to determine since school spending is frequently the responsibility of provincial governments).

For the purpose of gauging a nation's commitment to providing education for all, the relevant measure is not pupils-per-teacher but school-age-children-per-teacher. In Ethiopia's classrooms, for example, there are on average about 30 primary school pupils per teacher; but if all Ethiopian children were in school then the number would rise to 119.

Similarly, the average number of pupils per primary school teacher in Bhutan is 37; but if every child went to school the number would be 145.

The tables at right show what the best and worst pupil-teacher ratios in each region would be if all children of primary school age were attending school.

Class system

No. of primary school age children per teacher, 1990

SMALLEST		LARGEST	
Sub-Saharan Africa			
Mauritius	20	Burkina Faso	156
Botswana	27	Somalia	167
Gabon	28	Mali	188
Middle East and North Africa			
Libya	12	Morocco	41
U Arab Emirates	15	Yemen	44
Lebanon	16	Sudan	68
South Asia			
Sri Lanka	11	Bangladesh	81
Nepal	45	Bhutan	145
India	61	Afghanistan	175
East Asia and Pacific			
China	18	Viet Nam	34
Indonesia	20	Myanmar	36
Thailand	20	Papua N. Guinea	45
Central America and Caribbean			
Cuba	12	Guatemala	43
Panama	19	El Salvador	58
Mexico	26	Dominican Rep	61
South America			
Argentina	16	Ecuador	25
Uruguay	20	Colombia	27
Brazil	22	Bolivia	29
Industrialized countries			
Norway	6	Greece	20
Sweden	6	Japan	20
Austria	10	Ireland	26
Belgium	10		

SOURCES Teachers: UNESCO, Statistical yearbook 1993. Child population: United Nations Population Division, World population prospects: the 1992 revision, 1993

Tutelage and pupillage

Over the last decade, pupil-teacher ratios have remained stable or improved slightly in most developing nations. But in ten countries, class sizes actually increased in the 1980s.

Roll call

	No. of pupils per teacher 1980	1990	Rise
Central African Rep	60	90	30
Burundi	39	67	28
Senegal	46	58	12
Bangladesh	54	63	9
Congo	53	56	3
Lesotho	48	55	7
Mauritania	41	47	6
Pakistan	37	43	6
Bolivia	20	25	5
Oman	23	28	5

Spending gap

There are enormous differences between the amounts that different nations spend per pupil at all levels of education, ranging from over $2400 per head in the industrialized nations to less than $60 in sub-Saharan Africa. Much of the difference is accounted for by the much lower level of teachers' salaries in the developing world. But even taking that into account, very low levels of spending usually mean poorly paid and poorly supported teachers, struggling along without adequate funds for books, pencils, paper, or other materials.

Africa spends the least per pupil – but the most as a percentage of GNP. In 1980, schools in sub-Saharan Africa and South Asia spent roughly the same amount on each pupil. By 1990, spending per pupil had risen by almost 70% in South Asia and fallen by almost 7% in Africa.

Less for African schoolchildren

Annual government spending per pupil in pre-primary, primary, and secondary education, ($), 1980 and 1990

	1980	1990
Sub-Saharan Africa	62	58
East Asia/Pacific	32	76
South Asia	62	104
Arab States	179	263
Latin America/Caribbean	165	267
Industrialized nations	1327	2419

SOURCE UNESCO, World education report 1993

DISPARITY

10 nations see 30-point rise in literacy

Literacy rates have risen by 30 percentage points or more in at least ten nations over the last two decades. Most of the big gainers started from low levels in 1970, but in some the rise has been spectacular by historical standards. Several wealthier Middle Eastern nations make the list, including Saudi Arabia, where literacy rates have risen from 9% to 62% since 1970. But two of the poorest countries, Kenya and Yemen, take second and third places with impressive rises in literacy.

In some countries, there are disturbing discrepancies between literacy rates and current primary school completion rates. Madagascar, for example, has an official literacy rate of 80%, but only about a third of Madagascar's children are completing four years of primary school. The percentage of adults who are classed as literate in Angola, Chile, Haiti, Paraguay, Philippines and Thailand is also significantly higher than the percentage of children who are now reaching grade 5. Such discrepancies may in part be accounted for by lenient definitions of literacy, and by the fact that much larger numbers of children enrol in grade 1 than reach grade 5. Non-formal education, religious schools, and adult literacy campaigns may also have an impact in some countries.

10 on the up

According to national censuses, the ten countries with the largest rises in literacy rates over the last two decades are:

	% population literate 1970	% population literate 1990	% pt. rise
Saudi Arabia	9	62	53
Kenya	31	69	38
Yemen	5	39	34
Algeria	24	57	33
Botswana	41	74	33
Haiti	[illegible]	53	32
Angola	[illegible]	42	31
Madagascar	49	80	31
Ghana	30	60	30
Jordan	53	83	30

Source: UNESCO, [illegible] 1993 and earlier years

10 at 90%

Ten developing nations have lifted literacy levels to 90% or more. The Philippines makes the list despite its much lower per capita GNP.

	% population literate 1990
Jamaica	98
Korea, Rep	96
Uruguay	96
Argentina	95
Cuba	94
Philippines	94
Chile	93
Costa Rica	93
Thailand	93
Paraguay	90

Source: UNESCO, Statistical yearbook 1993

Poorer but more literate

Several of the world's poorest nations have achieved literacy rates of 75% or more.

In other countries with several times the wealth, literacy still languishes below 70%.

Poorer and more literate...

Per capita GNP below $1000, literacy over 75%

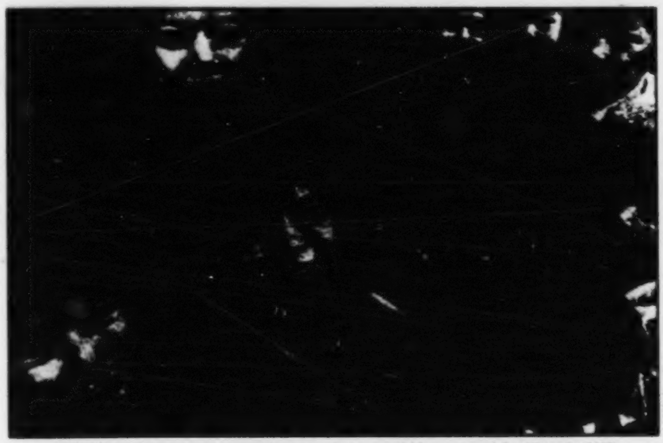
	Per capita GNP ($) 1992	% population literate 1990
Philippines	770	94
Viet Nam	240	88
Sri Lanka	540	88
Peru	950	85
Indonesia	670	82
Myanmar	220	81
Madagascar	230	80
China	380	78
Bolivia	680	78

Richer but less literate...

Per capita GNP $1500 and above, literacy below 70%

	Per capita GNP ($) 1992	% population literate 1990
Libya	5310	64
Saudi Arabia	7940	62
Gabon	4450	61
Iraq	1500	60
Algeria	1830	57
Tunisia	1740	57
Iran	2190	54

Source: GNP: World Bank, World Bank atlas 1994 1993 [illegible] UNESCO, Statistical yearbook 1993



China's children – twice as many reaching grade 5 as could be expected for China's GNP

China, Sri Lanka, Zimbabwe have best school reports

Some of the most populous countries of the developing world – including China, India, Indonesia and Egypt – have achieved better-than-expected levels of primary education.

The 'expected level' is the average for any country at that stage of economic development. The difference between the expected and actual level is the country's national performance gap (NPG).

Brazil, for example, has a per capita GNP of $2770 and could be expected to have 88% of its children reaching grade 5; in fact only 39% do so – a national performance gap of -49.

Sri Lanka, on the other hand, has a per capita GNP of $540 and so could be expected to have 55% of its children completing four years at primary school; in fact 95% of Sri Lankan children reach grade 5 – an NPG of +40.

The following tables show the best and worst performance gaps in primary education.

The NPGs of all nations – in child survival, nutrition, and education – can be found on pages 48 and 49.

Top 10

Countries where the percentage of children reaching grade 5 is significantly better than expected for GNP

	Actual %	Expected %	Difference (NPG)
China	86	46	+40
Sri Lanka	95	55	+40
Zimbabwe	94	59	+35
Albania	97	64	+33
Egypt	91	59	+32
Indonesia	83	58	+25
Yemen	78	55	+23
India	62	40	+22
Kenya	67	46	+21
Rwanda	60	39	+21

Bottom 10

Countries where the percentage of children reaching grade 5 is significantly worse than expected for GNP

	Actual %	Expected %	Difference (NPG)
Guatemala	41	68	-27
Mali	16	43	-27
Namibia	53	80	-27
Afghanistan	13	42	-29
Dominican Rep	41	70	-29
Saudi Arabia	63	92	-29
Guinea	19	55	-36
Haiti	12	48	-36
Gabon	50	90	-40
Brazil	39	88	-49

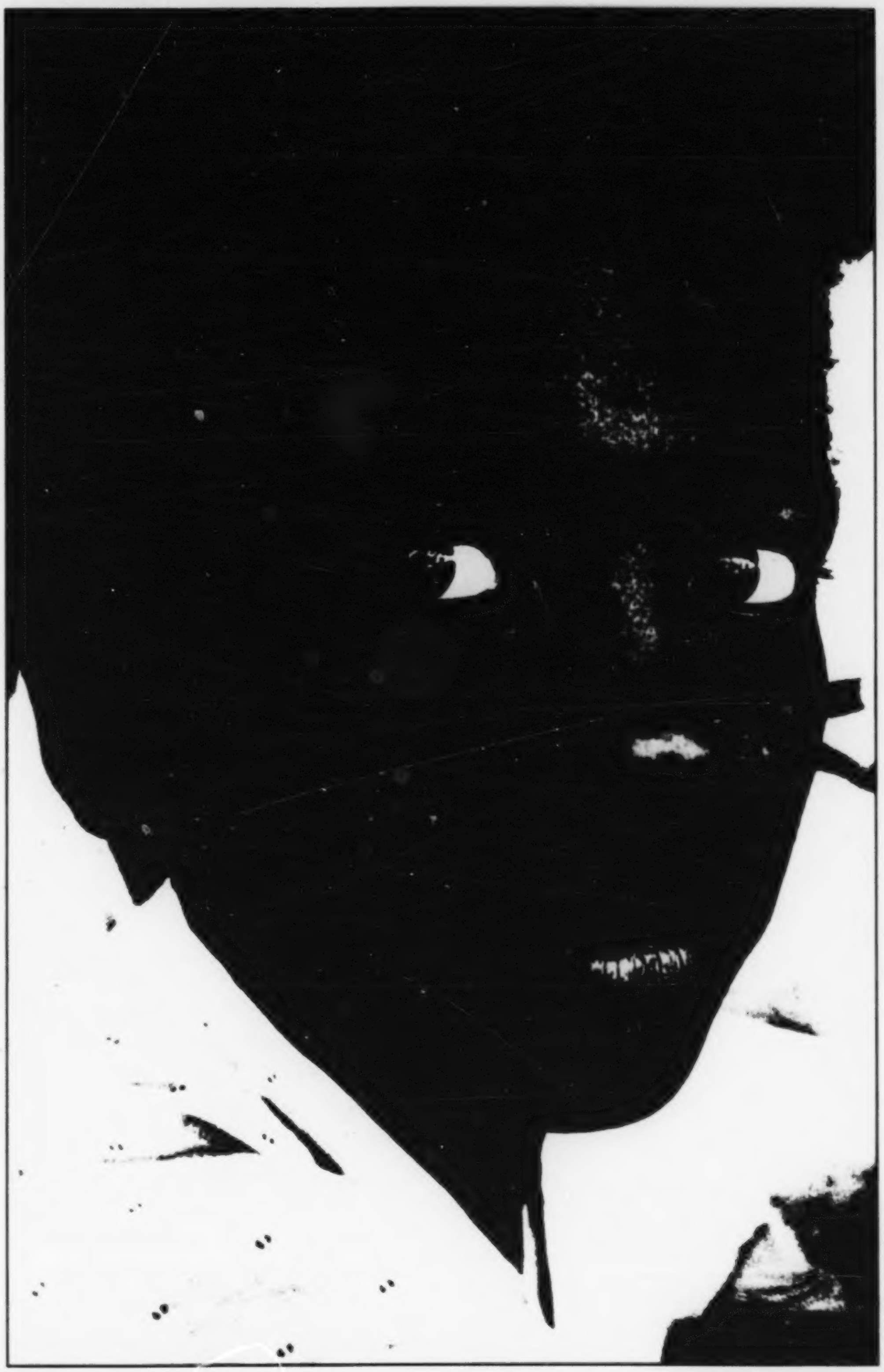
Source: GNP: World Bank, World Bank atlas 1994, 1993. Grade 5: UNESCO – unpublished data

COMMENTARY

Almost all the world's political leaders have agreed that family planning should be made available to all couples by the end of the century – now less than six years away.

Reaching that goal would bring immeasurable benefits to the lives of millions of women and children.

It could also help to decide whether the world's population stabilizes closer to 10 billion or 20 billion – a difference that may well be sufficient to determine success or failure in managing the transition to a sustainable future.



The decisive decade

Margaret Catley-Carlson

Margaret Catley-Carlson is President of the Population Council, an international non-profit research organization based in New York. Previously, she served Canada as Deputy Minister for Health and Welfare, President of the Canadian International Development Agency, and Deputy Director of UNICEF. In addition, she serves on the boards of several major international health and development organizations.

Less than 2% of government spending in the developing world – and less than 2% of all international aid – is currently devoted to family planning programmes. Meanwhile, there are an estimated 120 million women in the developing world who do not want to become pregnant but who are not using any modern method of family planning; as a result, at least one in every five pregnancies is unplanned and unwanted.

For all the rapid progress made in recent decades, the worldwide family planning effort is therefore still desperately inadequate.

But it is my belief that the true depth of this inadequacy can be seen not by looking at what is, but at what *might be*.

The benefits

To illustrate what might be, let us imagine for a moment that a major renewal of effort has succeeded in making family planning services universally available by the year 2000 – a goal agreed upon by almost all nations at the 1990 World Summit for Children. It is by no means an impossible dream. Much low-cost technology is already available. More is on the way. And great gains have also been made in our understanding of how family planning can be made available in human and respectful ways.

Here are five benefits that could be expected from this imaginary leap forward.

- A 50% decline in maternal deaths in the developing world if women who wish no further pregnancies had access to reliable methods of family planning. Half a million young women die every year from causes related to pregnancy and birth – more in India in a week than in Europe in a year.
- A radical decline in the number of abortions – estimated at 25 million per year in the developing world and as many again or more in the industrialized world.
- A 30% decline in child deaths – since most deaths under the age of five are the deaths of children born within two years of a previous birth, or to mothers under 18 or over 35. Delaying births until mothers wish to become pregnant would reduce under-five deaths by 24-30%, and by even more where the current interval between births is under two years.
- A new chance for young girls: very young mothers, under the age of 18, run three times the risk of death of mothers aged 20-29; very few of them are able to stay in school, or develop their potential.
- A whole new pattern of family investment: outside of Africa, at least half of all married women do not want any more children. Within Africa, half would like to postpone the next birth or do not want any more children. When women and families can devote their energies and resources to their existing children and to themselves, family nutrition and child care improve, and women have more time and energy to improve their own situations.

In other words, almost all of the other indicators of well-being used in *The Progress of Nations* – including health, nutrition, education, and progress for women – would show a very substantial improvement if the goal of universal family planning availability were to be met.

Stabilizing populations

I believe that these benefits add up to an overwhelming case for an increased family planning effort in the 1990s. And I believe that the case would still be overwhelming even if there were no such thing as a population problem. But if we also take into account the potential contribution of family planning to lower rates of population growth, then it must be said that to fail to make family planning universally available by the end of the 20th century would be to add unforgivable folly to inexcusable neglect.

It is always important to acknowledge, when referring to the population problem, that every child born into the industrialized world consumes 20 to 30 times as much of the world's resources in a lifetime as a child born into the developing world, and that current consumption patterns in the North pose the greatest immediate threat to the biosphere. But this does not mean we can ignore the fact that rapid population growth in the South is already degrading the environment and undermining the economic prospects of many hundreds of millions of people.

The 1990s will be the decisive decade. And the next few years will largely decide whether eventual world population stabilizes closer to 10 billion, which is currently the most optimistic forecast, or at 20 billion or more, which is the high-end prediction. The difference between these two figures might well be the difference between success and failure in managing the transition to sustainable development. If we are to make a serious attempt to stay with the lower figure, then a major renewal of the family planning effort in the mid-1990s is clearly a precondition.

Realizing these multiple potential benefits of universally available family planning services is one of the most complex as well as one of the most important of all tasks facing humanity in the years immediately ahead. We must meet existing demand. But in much of the world, desired family size is still considerably higher than replacement level (though I agree with my colleague Gertrude Mongella (page 31) when she asserts that 'desired family size' may say more about social pressures than about women's own wishes). We must therefore also try to create the conditions which will increase demand for smaller families. Briefly, those conditions include rising incomes, falling child death rates, rising levels of female education, progress towards gender equality, and the widespread availability of the kind of family planning services in which people can have confidence.

As this list shows, the goal of making family planning universally available reinforces, and is reinforced by, almost all of the other social goals discussed in this issue of *The Progress of Nations*.

Population momentum

Population momentum is that enormous force which arises from the fact that one third of our world today is under the age of 15. *Even if* each of these young people accepts family planning, and *even if* each new couple decides to have but two children, enormous population growth will occur. Again, the positive choices for individual people are those that will also promote the global interest in slowing this momentum. There is no reason to accept that a third of today's 14-year-old girls will be mothers by 20. We can educate them, protect them, help them develop, invest in their future – and our own.

Finally, I want to stress my own conviction that the world now has enough knowledge and experience to be able to meet the existing demand for family planning, and to increase that demand, in ways that are totally human and totally respectful of human rights. We must now use that knowledge and experience as the basis for a major renewal of the family planning effort. And we must do this for the sake of the women and children of today – and for the world of tomorrow.

FAMILY PLANNING

LEAGUE TABLE OF

These pages rank all nations by the percentage of married women of child-bearing age who use family planning.

Since 1960, the family planning rate in the developing world has risen from about 10% to 55%, and average family size has fallen steeply in every region except Africa.

Despite this progress, there are today an estimated 120 million women in the developing world who do not want to become pregnant but who are not using family planning.

As a result, one pregnancy in every five is unwanted.

SUB-SAHARAN AFRICA

		%
1	**Mauritius**	75
2	**South Africa**	50
3	**Zimbabwe**	43
4	**Botswana**	33
4	**Kenya**	33
6	**Namibia**	29
7	**Lesotho**	23
8	**Rwanda**	21
9	**Madagascar**	17
10	**Cameroon**	16
11	**Zambia**	15
►	*Regional average*	*14*
12	**Ghana**	13
12	**Malawi**	13
14	**Togo**	12
15	**Tanzania**	10
16	**Benin**	9
16	**Burundi**	9
18	**Burkina Faso**	8
19	**Senegal**	7
20	**Liberia**	6
20	**Nigeria**	6
22	**Mali**	5
22	**Uganda**	5
24	**Mauritania**	4
24	**Mozambique**	4
24	**Niger**	4
24	**Sierra Leone**	4
28	**Côte d'Ivoire**	3
29	**Ethiopia**	2
30	**Somalia**	1
	Angola	OLD DATA
	Chad	OLD DATA
	Guinea	OLD DATA
	Guinea-Bissau	OLD DATA
	Zaire	OLD DATA
	C. African Rep.	NO DATA
	Congo	NO DATA
	Eritrea	NO DATA
	Gabon	NO DATA

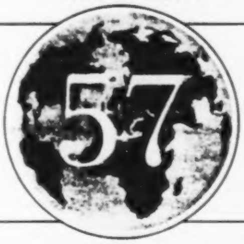
MIDDLE EAST and NORTH AFRICA

		%
1	**Turkey**	63
2	**Syria**	52
3	**Algeria**	51
4	**Tunisia**	50
5	**Iran**	49
6	**Egypt**	47
►	*Regional average*	*44*
7	**Morocco**	42
8	**Jordan**	35
8	**Kuwait**	35
10	**Iraq**	18
11	**Oman**	9
11	**Sudan**	9
13	**Yemen**	7
	Lebanon	OLD DATA
	Libya	NO DATA
	Saudi Arabia	NO DATA
	U. Arab Emirates	NO DATA

SOUTH ASIA

		%
1	**Sri Lanka**	62
2	**India**	43
3	**Bangladesh**	40
►	*Regional average*	*40*
4	**Nepal**	23
5	**Pakistan**	12
6	**Bhutan**	2
	Afghanistan	OLD DATA

WORLD AVERAGE



% using family planning

Only one third have 1990s statistics

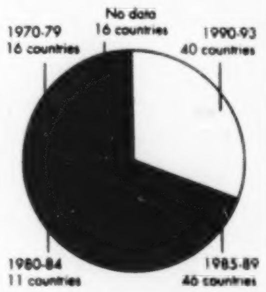
Statistics for family planning are generally better than for most other social indicators; all of the information presented in these tables is based on direct measurement in the countries concerned rather than on the estimation of trends or the use of mathematical models.

Yet as the chart shows, only 40 out of 129 countries have family planning statistics dating from the 1990s – and about one third have no data at all for the last ten years.

FURTHER INFORMATION United Nations Population Division, *Levels and trends in contraceptive use as assessed in 1993*, forthcoming.

Data dates

Latest year of data on family planning rates (129 countries)



SOURCES DHS and other surveys.

USE RATES

EAST ASIA and PACIFIC

		%
1	**China**	83
2	**Hong Kong***	81
3	**Korea, Rep.**	79
4	**Singapore**	74
▶	*Regional average*	*74*
5	**Thailand**	66
6	**Viet Nam**	53
7	**Indonesia**	50
8	**Malaysia**	48
9	**Philippines**	40
10	**Myanmar**	13
11	**Papua New Guinea**	4
	Cambodia	NO DATA
	Korea, Dem.	NO DATA
	Lao Rep.	NO DATA
	Mongolia	NO DATA

* Colony

CENTRAL AMERICA and CARIBBEAN

		%
1	**Costa Rica**	75
2	**Cuba**	70
3	**Jamaica**	66
4	**Panama**	58
5	**Dominican Rep.**	56
6	**El Salvador**	53
6	**Mexico**	53
6	**Trinidad and Tobago**	53
▶	*Regional average*	*51*
9	**Nicaragua**	49
10	**Honduras**	47
11	**Guatemala**	23
12	**Haiti**	10

SOUTH AMERICA

		%
1	**Argentina**	74
2	**Brazil**	66
2	**Colombia**	66
▶	*Regional average*	*65*
4	**Peru**	59
5	**Ecuador**	53
6	**Paraguay**	48
7	**Bolivia**	30
	Chile	OLD DATA
	Venezuela	OLD DATA
	Uruguay	NO DATA

Regional averages are weighted for population size

World average excludes the nations of the former Soviet Union and former Yugoslavia

OLD DATA refers to surveys conducted before 1980

INDUSTRIALIZED COUNTRIES

		%
1	**France**	80
2	**Belgium**	79
3	**Czech Rep.**	78
3	**Denmark**	78
3	**Sweden**	78
6	**Australia**	76
6	**Netherlands**	76
6	**Norway**	76
9	**Germany**	75
10	**Slovakia**	74
10	**United States**	74
12	**Canada**	73
12	**Hungary**	73
14	**United Kingdom**	72
▶	*Group average*	*72*
15	**Austria**	71
15	**Switzerland**	71
17	**Japan**	64
18	**Spain**	59
	Bulgaria	OLD DATA
	Finland	OLD DATA
	Italy	OLD DATA
	New Zealand	OLD DATA
	Poland	OLD DATA
	Portugal	OLD DATA
	Romania	OLD DATA
	Albania	NO DATA
	Greece	NO DATA
	Ireland	NO DATA
	Israel	NO DATA

TARGET

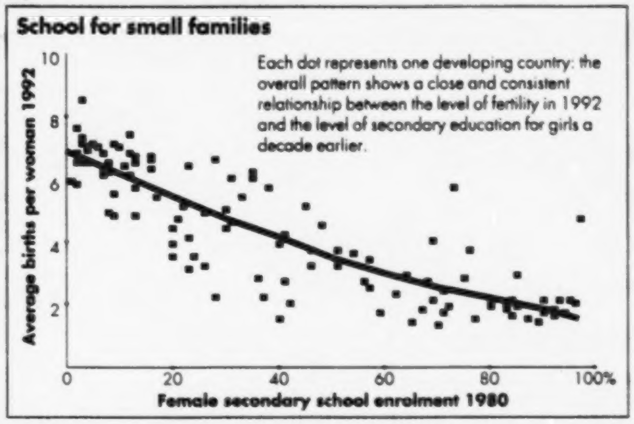
Family planning information and services to be made available to all couples.

FOR THE YEAR 2000

More schooling, fewer births

The education of girls has been shown to be one of the most powerful determinants of falling family size. Educated women usually have more opportunities, more awareness of family planning, and more decision-making power. They are also more likely to marry late, to postpone the first pregnancy, to leave more time between births, and to have fewer children in total.

As the chart shows, the effect of secondary education is particularly strong.



SOURCES Total fertility rate: United Nations Population Division, *World population prospects: the 1992 revision*, 1993. Education: UNESCO, *Statistical yearbooks*, 1993 and earlier years.

Fertility rates have been falling for many years in every region of the world except Africa – where the first signs of decline are now becoming visible in countries such as Botswana, Kenya, and Zimbabwe.

But the momentum of population growth will ensure that most developing countries will treble their total numbers before stabilizing.

According to World Bank projections, more than half the nations of sub-Saharan Africa will see their present populations increase fivefold before stabilizing.

Ethiopia – what future for its children if population rises eightfold?

50 heading for 50 million

When world population eventually stabilizes, there will be more than double today's number of people on the planet, according to World Bank projections.

Although most industrialized countries are already close to zero population growth, many developing countries are expected to keep on growing well into the 21st century.

The tables show the present and predicted populations of all countries that are expected to grow to more than 50 million people. They reveal that both Ethiopia and Nigeria will reach the 400 million mark (more than the current population of Western Europe) and that Iran will eventually have almost twice the population of the USA today.

China and India – with about 1.9 billion people each – will vie for the title of most populous nation.

A renewed effort to reach the year 2000 goals for health, family planning, and education (especially for girls) could bring about a major reduction in these projected figures.

	1990 population (millions)	Stabilized population (millions)	Multiplication factor
China	1153	1886	1.6
India	846	1855	2.2
Iran	58	490	8.4
Ethiopia	47	400	8.5
Nigeria	109	398	3.7
Pakistan	118	397	3.4
Indonesia	184	358	1.9
United States	250	334	1.3
Brazil	149	304	2.0
Bangladesh	114	255	2.2
Mexico	84	184	2.2
Zaire	37	171	4.6
Viet Nam	67	159	2.4
Tanzania	26	144	5.5
Philippines	62	137	2.2
Japan	124	128	1.0
Afghanistan	17	127	7.7
Kenya	24	124	5.3
Egypt	52	120	2.3
Turkey	56	120	2.1
Yemen	12	109	9.3
Thailand	55	102	1.9
Sudan	25	101	4.0
Mozambique	14	96	6.8
South Africa	38	96	2.5
Myanmar	42	96	2.3

	1990 population (millions)	Stabilized population (millions)	Multiplication factor
Uganda	18	91	5.2
Saudi Arabia	15	89	6.0
Iraq	18	85	4.7
Germany	79	80	1.0
Algeria	25	78	3.1
Niger	8	72	9.3
Morocco	25	69	2.8
Syria	12	66	5.3
Rwanda	7	65	9.3
United Kingdom	57	64	1.1
Côte d'Ivoire	12	63	5.3
France	57	63	1.1
Malawi	10	62	6.5
Ghana	15	62	4.1
Colombia	32	62	1.9
Angola	9	61	6.6
Nepal	20	58	3.0
Mali	9	57	6.2
Korea, Rep.	43	56	1.3
Italy	58	55	1.0
Cameroon	12	53	4.6
Argentina	32	53	1.6
Peru	22	50	2.3
Poland	38	50	1.3

SOURCE: Eduard Bos and others, World population projections 1992-93 edition, Johns Hopkins University Press for World Bank, 1992

Knowing how is knowing where

Recent surveys in 35 developing countries have shown the importance of knowing where to go for family planning services. Most women today know of at least one modern method of preventing pregnancy, but far fewer know where to go for practical help and advice.

In countries where over a third of women give birth before the age of 18, only 50%, on average, knew of a source of family planning advice. In countries where less than 10% of women give birth before age 18, the average was almost 97%.

Teenage pregnancy threatens the health and educational opportunities of girls; and child death rates in the developing world are approximately 50% higher for babies born to girls under the age of 18.

Less knowledge

	% of women who know family planning source	% aged 20-24 mothers by 18
Niger	33	53
Mali	30	47
Cameroon	54	46
Liberia	48	44
Uganda	74	42
Nigeria	34	35
Zambia	81	34

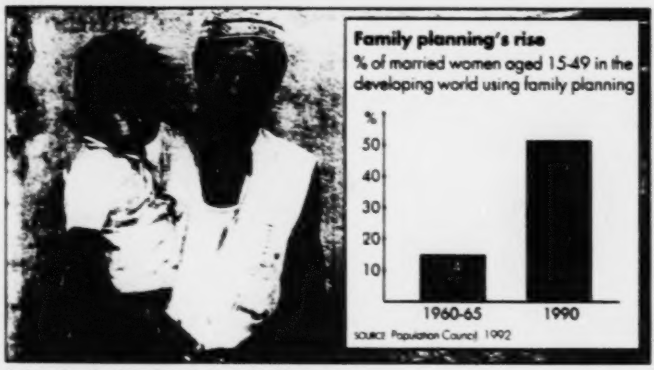
More knowledge

	% of women who know family planning source	% aged 20-24 mothers by 18
Thailand	99	9
Jordan	95	8
Morocco	94	7
Sri Lanka	98	5
Tunisia	97	3

SOURCE: Demographic and health surveys in 35 nations, IRD/Macro International, 1986-1992

Uganda – 42% are mothers by 18

DISPARITY



Family planning's rise

% of married women aged 15-49 in the developing world using family planning

SOURCE Population Council 1992

India – family planning effort now highly rated

India and Bangladesh earn high marks

On a scale of 1 to 100, the family planning effort in the average developing country rates a score of 44, according to an 'index of family planning effort' devised by the Population Council and the UN Population Fund.

First used in the early 1980s – when the average rating was just 29 – the index takes into account 30 different factors, from family planning availability to minimum age of marriage.

Two of the world's poorest and most populous countries – India and Bangladesh – earn a rating of 70.

The following tables show each country's 1989 rating out of 100.

Family planning effort

Strong							
China	84	Sri Lanka	77	Bangladesh	70	Tunisia	68
Korea, Rep.	80	Thailand	77	India	70	Viet Nam	67
Indonesia	78	Mexico	76	El Salvador	68		
Taiwan	78	Botswana	72	Mauritius	68		
Moderate							
Trinidad/Tobago	66	South Africa	60	Morocco	55	Lebanon	50
Cuba	65	Nepal	58	Dominican Rep	54	Peru	50
Egypt	65	Chile	57	Costa Rica	53	Zambia	49
Jamaica	65	Ecuador	57	Korea, Dem	52	Pakistan	48
Honduras	63	Kenya	57	Panama	52	Philippines	48
Malaysia	63	Zimbabwe	56	Venezuela	52		
Singapore	63	Guyana	55	Ghana	50		
Colombia	61	Iran	55	Guatemala	50		
Weak							
Algeria	45	Uruguay	42	Afghanistan	35	Yemen	28
Burkina Faso	45	Tanzania	41	Sierra Leone	35	Zaire	28
Lesotho	45	Burundi	40	Cameroon	34	Mozambique	27
Turkey	45	Guinea	40	Uganda	33	Papua N. Guinea	26
Senegal	44	Madagascar	40	Brazil	32	Bolivia*	23
Syria	44	Angola	39	Ethiopia	32	Bhutan	22
Nigeria	43	Mali	38	Jordan	31	Argentina	21
Rwanda	43	Niger	38	Togo	29	Mauritania	21
C. African Rep	42	Congo	36	Benin	28		
Haiti	42	Paraguay	36	Guinea-Bissau	28		
Very weak or none							
Chad	20	Namibia	11	Liberia	3	Libya	0
Sudan	20	Myanmar	10	Iraq	1	Saudi Arabia	0
Côte d'Ivoire	16	Cambodia	9	Somalia	1		
Malawi	16	Lao Rep	8	Gabon	0		
U. Arab Emirates	12	Oman	5	Kuwait	0		

Nine African nations step up family planning effort

A comparison of family planning efforts at the beginning and end of the 1980s shows that 12 developing countries increased their ratings by 30 points or more. The measure used is the family planning effort index devised by the Population Council and the UN Population Fund (story this page).

Most of the countries that show a big leap forward started from a very low effort level in the early 1980s. Nine of the 12 are in Africa, where debt, recession, and falling commodity prices have made progress of all kinds difficult over the last decade.

Of the 87 nations surveyed at both dates, 61 improved their rating by at least 10 points. Nine were judged to have fallen back.

Most progress

	Score out of 100 1982	Score out of 100 1989	Increase
Botswana	27	75	48
Iran	11	57	46
Burkina Faso	4	45	41
Honduras	25	63	38
Guinea	5	40	35
Ghana	18	52	34
Niger	5	38	33
Syria	11	44	33
Zambia	16	49	33
C. African Rep	10	42	32
Lesotho	14	45	31
Madagascar	9	40	31

Least progress

	Score out of 100 1982	Score out of 100 1989	Decrease
Dominican Rep	55	54	-1
Saudi Arabia	1	0	-1
Iraq	3	1	-2
Kuwait	5	0	-5
Philippines	56	49	-7
Colombia	71	62	-9
Somalia	10	1	-9
Brazil	43	32	-11
Liberia	22	3	-19

This list includes only those countries where the average number of births per woman is greater than two

The top countries...

One quarter of the total score in the family planning effort index is awarded for making family planning easily accessible in all communities, rural as well as urban. The table shows the best scores in each region.

1989	Access out of 100	1989	Access out of 100
Sub-Saharan Africa		**East Asia and Pacific**	
Mauritius	90	China	100
Botswana	85	Korea, Rep	100
Niger	48	Singapore	100
Kenya	43	Thailand	94
Lesotho	43	Malaysia	79
Middle East and North Africa		**Central America and Caribbean**	
Tunisia	77	Trinidad and Tobago	100
Lebanon	67	Mexico	93
Iran	64	Cuba	92
Egypt	60	El Salvador	84
Turkey	58	Dominican Rep	83
South Asia		**South America**	
India	87	Ecuador	93
Sri Lanka	84	Colombia	81
Bangladesh	78	Chile	79
Nepal	45	Brazil	61
Pakistan	28	Uruguay	59

SOURCE Tables: data for W. Parker Mauldin and John A. Ross, [illegible], 1982-89, Studies in family planning, vol. 22, no. 6, November/December 1991. Bar chart: John A. Ross and others, [illegible] 1991, Population Council, 1992

COMMENTARY

Education can give a woman more awareness, more choice, and more confidence. It raises her value and status in the eyes of her husband, her family, and her community.

Family planning can give a woman more opportunity, more time, and better health.

More attention to a woman's health needs can prevent the serious problems which undermine her position and capacities.

The right technologies can save many hours of daily drudgery, releasing time and energy for other struggles.

Change for the last and the least

Gertrude Mongella

Gertrude Mongella is the Secretary-General of the Fourth World Conference on Women to be held in Beijing in September 1995. After holding several ministerial posts in the Government of Tanzania, she served as her country's High Commissioner to India before taking up her present appointment.

My grandfather was a man of considerable prestige, much sought after for his services and advice. The source of this prestige was not wealth; it was the fact that he had ten children, that all of them survived, and that eight of them were boys.

In that sense, little has changed in the decades which have seen so much change in other spheres. In Africa, as in many parts of the world, a woman who gives birth to three boys will consider herself fortunate, and be much admired, while her neighbour who has three daughters will be an object of pity. If the two meet, both are shy and embarrassed at the great contrast in their fortunes. If the same circumstance arose in those many parts of Asia in which the dowry system still prevails, then the consequences would be even more severe: a family with three girl children might well face financial ruin.

The challenge we face is the challenge of moving to the point at which these all-important differences are of no importance. It is an immensely long road to travel. The Fourth World Conference on Women, to be held in Beijing in 1995, will be both a milestone and a signpost.

The lever of education

The challenge is essentially one of finding practical levers to bring about change in the years immediately ahead. And I think there can be little doubt that the most powerful of those levers is education. An educated woman almost always has more value and status in the eyes of her husband, her family, and her community. She is likely to have more awareness, more opportunities, more choice, and more confidence. Even if all else remains unchanged, and even if the educated woman still has no opportunities outside the home, her position is still likely to be transformed; she is more likely, for example, to share in family decisions about how many children to have, how to bring them up, how to spend money, how to organize domestic life, and how to care for her own and her family's health. Her husband will also treat her in a different, less dictatorial way, and she will be less susceptible to bullying and intimidation by her in-laws. All of this inevitably, if slowly, raises the woman's status, and makes it more likely that the gender conditioning of the next generation will be less severely discriminatory.

Family planning

The second great force for transforming the lives of women in the developing world is the spread of family planning services. The number of children born to a woman has a fundamental impact on her health, on her time and energies, on her freedom and opportunities, and on the chances of her children growing up healthy and educated. This topic is also discussed by Margaret Catley-Carlson (see page 25). I will only add that even the surveys which reveal so much unmet demand for family planning probably underestimate the real requirements. Women know the real cost of having too many children too close together; they know what it means for their health and their lives and their opportunities. And many women also know that every time they become pregnant, they are putting themselves in danger; a girl growing up in Africa today faces an appalling 1-in-20 risk of dying during pregnancy or childbirth. Society may tell her that she should have seven or eight children. Her husband and his parents may tell her the same. Her status may well depend upon it. And she may well declare this same wish to conform to prevailing social values. But without such pressures, I do not believe that any woman in her right mind *wants* eight children.

Women's health

A third lever is direct action to improve the health of women and girls. Too often, females eat last and least; and if they want to be well thought of and well treated, then they are taught that they must, in all circumstances, consider the needs of others first. When it comes to health, they are expected to simply put up with problems which, in males, would be complained about and acted upon. A girl or a woman is expected to work even if she is quite seriously ill; a boy with a headache will be told to lie down. A woman is expected to bear pain and suffering with fortitude. She is told she will shame her parents if she cries in labour. And she knows that the more suffering she can bear the more she will be praised. Boys – and often men too – are fussed over and attended to when they are the slightest bit ill.

This neglect of the health needs of women leads to serious problems and to a further undermining of their position and their capacities. In the developing world, over 40% of women suffer from iron-deficiency anaemia. In some, the lack of attention to health and nutrition during childhood and puberty leads to great difficulty during the years of childbearing and is a major cause of the low-birth-weight syndrome which does so much to perpetuate malnutrition and poor growth from one generation to the next. Worldwide, 500,000 women die every year from the complications that arise during pregnancy and labour – and many times that number are left with injuries, illnesses, and disabilities which can be embarrassing, painful, debilitating, lifelong – and which undermine their health and their strength and their opportunities.

Women's technology

A fourth powerful lever is the kind of technology that lightens the burden on women in the developing world rather than increasing it. These technologies are not usually expensive. Standpipes and handpumps, small ploughs and tools to help with the weeding and harvesting, powered grain-grinding mills, and cooking stoves that mean that only half as much firewood needs to be collected – these are the technologies that could save millions of women hours of drudgery every day, improving health and releasing time and energy for more productive purposes.

By and large, the technology already exists. But there is too big a gap between those who create it and those who need it, and there is too much bureaucracy in the attempt to make technology available to poor and often illiterate women. The result is a plethora of appropriate-technology exhibitions and demonstration centres in capital cities – while millions of women expend their time, their health, and their energies in fetching and carrying and pounding.

Synergisms

It is this powerful set of practical, affordable, and mutually reinforcing changes – in education, family planning, health, and women's technologies – that could do most to bring about the beginnings of a transformation for many millions of women in the developing world.

PROGRESS FOR WO

LEAGUE TABLE OF

No single statistic can adequately measure the status of women. The indicator chosen for these tables is the female literacy rate as a percentage of the male literacy rate.

In countries with near-universal literacy, this criterion is obviously less revealing of male/female inequalities. Some other method of measuring progress for women is required.

But for most of the developing world, where average literacy rates stand at 75% for men and 55% for women, the literacy gap is a reasonable overall guide to the degree of inequality between the sexes.

SUB-SAHARAN AFRICA

		%
1	**South Africa**	96
2	**Mauritius**	88
3	**Madagascar**	83
4	**Zimbabwe**	81
5	**Zambia**	80
6	**Botswana**	77
7	**Kenya**	74
8	**Ghana**	73
8	**Zaire**	73
▶	*Regional average*	*67*
10	**Burundi**	66
10	**Gabon**	66
12	**Cameroon**	65
12	**Nigeria**	65
14	**Congo**	63
15	**Côte d'Ivoire**	60
16	**Mali**	59
17	**Liberia**	58
17	**Rwanda**	58
19	**Uganda**	56
20	**Togo**	55
21	**Angola**	52
21	**Malawi**	52
23	**Benin**	50
24	**Central African Rep.**	48
24	**Ethiopia**	48
24	**Guinea-Bissau**	48
24	**Senegal**	48
28	**Mozambique**	47
29	**Mauritania**	45
30	**Chad**	43
30	**Niger**	43
32	**Somalia**	39
33	**Guinea**	37
34	**Sierra Leone**	35
35	**Burkina Faso**	32
	Tanzania	OLD DATA
	Eritrea	NO DATA
	Lesotho	NO DATA
	Namibia	NO DATA

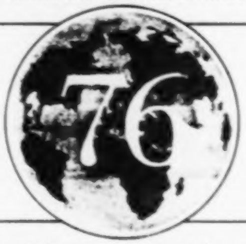
MIDDLE EAST and NORTH AFRICA

		%
1	**Kuwait**	87
2	**Lebanon**	83
3	**Jordan**	79
3	**Turkey**	79
5	**Tunisia**	76
6	**Iraq**	70
7	**Libya**	67
▶	*Regional average*	*67*
8	**Algeria**	66
8	**Iran**	66
8	**Saudi Arabia**	66
11	**Syria**	65
12	**Morocco**	62
13	**Egypt**	54
14	**Yemen**	49
15	**Sudan**	28
	U. Arab Emirates	OLD DATA
	Oman	NO DATA

SOUTH ASIA

		%
1	**Sri Lanka**	90
2	**India**	55
▶	*Regional average*	*54*
3	**Bhutan**	49
4	**Bangladesh**	47
5	**Pakistan**	45
6	**Nepal**	34
7	**Afghanistan**	32

DEVELOPING WORLD AVERAGE



Female literacy as % of male literacy

Nothing equates like equality

The tables on these pages are based on the female literacy rate as a percentage of the male literacy rate. It is important to keep in mind that this is intended as a guide to gender inequality – not literacy levels. A country in which only 10% of the population is literate, for example, would still earn the maximum rating of 100 providing that women and men had the same literacy rate. Conversely, a nation with much higher overall literacy would earn a rating of only 25 if male literacy was 80% and female literacy was 20%.

Most countries have reasonably recent data on literacy, but international comparisons must be treated with care as different countries may use different definitions of literacy. The definition most widely used is that recommended by UNESCO – *"a literate person can, with understanding, both read and write a short simple statement on his or her everyday life."*

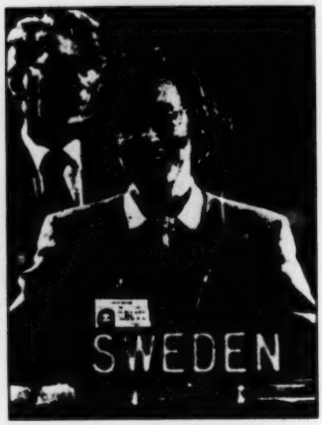
[illegible] UNESCO, *Statistical yearbooks*, 1993 and earlier years.

In the established industrial societies, the progress of recent years has still left most women a long way short of equality. Compared with men, they are underrepresented in the professions and in politics, underpaid in the workforce, and overworked by the multiple responsibilities of their domestic, child-caring, and income-earning roles.

In the developing world, as these pages show, discrimination can take harsher forms, ranging from female genital mutilation to the lifelong discrimination in nutrition and health care that is eventually revealed by the statistics on low-birth-weight.

PROGRESS FOR W

ACHIEVEMENT AND



Seychelles and Sweden – two of only six parliaments where a quarter of members are women

Only one politician in ten is a woman

Women's share of seats in the world's parliaments has fallen from 13% to 10% since the worldwide situation was last assessed in 1991, according to the Inter-Parliamentary Union.

Top 10
% women MPs 1993

Seychelles	46
Finland	39
Norway	36
Sweden	34
Denmark	33
Netherlands	29
Iceland	24
Cuba	23
Austria	21
China	21

Zero rated
No women MPs

- Antigua/Barbuda
- Belize
- Bhutan
- Djibouti
- Jordan
- Kiribati
- Kuwait
- Mauritania
- Papua N. Guinea
- Saint Lucia
- U. Arab Emirates

Where parliaments are 95% male
% women MPs 1993

[illegible]	1	Tajikistan	3
Korea, Rep.	1	Tonga	3
Morocco	1	Barbados	4
Pakistan	1	Belarus	4
Yemen	1	Cambodia	4
Azerbaijan	2	Colombia	4
Egypt	2	Haiti	4
Japan	2	Liechtenstein	4
Lebanon	2	Maldives	4
Lesotho	2	Mongolia	4
Mali	2	Romania	4
Malta	2	Samoa	4
Moldova	2	Singapore	4
Nigeria	2	Thailand	4
Turkey	2	Tunisia	4
Iran	3	Argentina	5
Kenya	3	Botswana	5
Marshall Islands	3	Côte d'Ivoire	5
Mauritius	3	Malaysia	5
Nepal	3	Sri Lanka	5
Paraguay	3	Sudan	5
South Africa	3	Turkmenistan	5

Going forwards
Countries where the proportion of women in parliament has risen by 5 percentage points or more since 1987

	% women MPs 1987	% women MPs 1993	% pt. rise
Seychelles	24	46	22
Spain	6	16	10
Austria	12	21	9
Netherlands	20	29	9
Algeria	2	10	8
Dominican Rep	5	12	7
Finland	32	39	7
Honduras	5	12	7
Suriname	6	13	7
United States	5	11	6
Uruguay	0	6	6
Venezuela	4	10	6
El Salvador	3	8	5
Sweden	29	34	5

Going backwards
Countries where the proportion of women in parliament has fallen since 1987

	% women MPs 1987	% women MPs 1993	% pt. fall
Albania	29	6	−23
Mongolia	25	4	−21
Hungary	21	7	−14
Cuba	34	23	−11
Poland	20	10	−10
Bulgaria	21	13	−8
Pakistan	9	1	−8
Cape Verde	15	8	−7
Gabon	13	6	−7
Angola	15	10	−5
Italy	13	8	−5

Source: Inter-Parliamentary Union, Distribution of seats between men and women in the 171 national parliaments existing as at 30 June 1993, 1993, and Distribution of seats between men and women in national parliaments, statistical data from 1945 to 30 June 1991, Reports and documents no. 18, 1991. For two-chamber parliamentary systems, only the lower house is counted.

Sweden and Finland lead on maternity leave

All of the industrialized nations except Australia and the USA now provide paid and job-protected maternity leave for employed women. The actual rate of pay varies between 50% and 100% of salary. In some countries, paternity leave is also provided for.

In some nations, the idea of maternity leave alone appears to be becoming outdated. The emphasis is switching, especially in the Nordic countries, to the idea of parental leave, ranging from 6 months to 3 years at varying rates of pay. The nations listed in bold type below guarantee this additional leave, paid and job-protected, to enable parents to spend more time with their children during the early years.

The United States has recently enacted a bill giving women the right to 12 weeks unpaid but job-protected maternity leave.

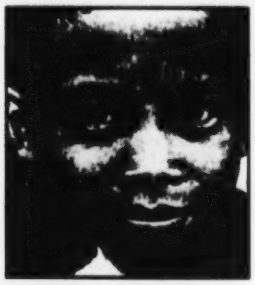
Paid maternity leave 1991-92

	No. of weeks	Rate of pay (% of salary)
Sweden	52/65	80/fixed
Finland	18/46	80
Denmark	28	100
Iceland	26	Fixed
New Zealand	26	Fixed
Italy	22	80
Greece	21	50
Norway	6/18	100/80
United Kingdom	6/18	90/fixed
Austria	16	100
France	16	84
Luxembourg	16	100
Netherlands	16	100
Spain	16	75
Canada	15	60
Germany	14	100
Japan	14	60
Belgium	14	75/79
Ireland	14	70
Portugal	13	100
Switzerland	10	Varies
Australia	0	0
United States	0	0

Bold type nations providing additional child-care leave

Source: Sheila B. Kamerman and Alfred J. Kahn, Columbia University School of Social Work, February 1994, research sponsored by Carnegie Corporation and Spencer Foundation

EQUALITY IN LITERACY



EAST ASIA and PACIFIC

		%
1	**Philippines**	99
2	**Thailand**	96
3	**Korea, Rep.**	95
4	**Viet Nam**	91
5	**Indonesia**	85
6	**Lao Rep.**	83
7	**Myanmar**	81
▶	*Regional average*	*81*
8	**Malaysia**	80
8	**Singapore**	80
10	**China**	78
11	**Papua New Guinea**	58
12	**Cambodia**	46
	Hong Kong'	OLD DATA
	Korea, Dem.	NO DATA
	Mongolia	NO DATA

CENTRAL AMERICA and CARIBBEAN

		%
1	**Jamaica**	101
2	**Costa Rica**	100
3	**Panama**	99
4	**Cuba**	98
5	**Trinidad and Tobago**	97
6	**Dominican Rep.**	96
7	**Mexico**	94
8	**Honduras**	93
▶	*Regional average*	*93*
9	**El Salvador**	92
10	**Haiti**	80
11	**Guatemala**	75
	Nicaragua	NO DATA

SOUTH AMERICA

		%
1	**Venezuela**	103
2	**Argentina**	99
2	**Brazil**	99
2	**Chile**	99
2	**Uruguay**	99
6	**Colombia**	98
▶	*Regional average*	*97*
7	**Paraguay**	96
8	**Ecuador**	93
9	**Peru**	86
10	**Bolivia**	84

Regional averages are weighted for population size

OLD DATA refers to data before 1980

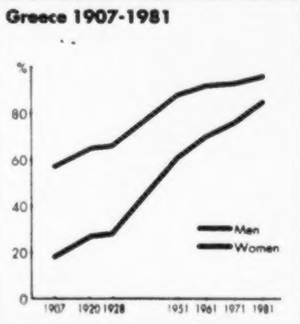
NO DATA means no data later than 1980

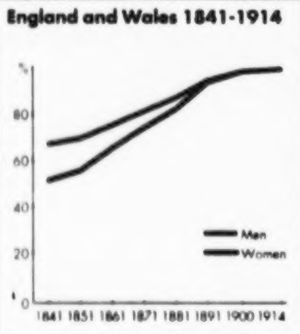
INDUSTRIALIZED COUNTRIES

By and large, equality in literacy has been achieved in the industrialized nations. But as the charts show, there were wide gaps between male and female education during the earlier stages of the climb towards near-universal literacy.

Historically, the gender gap is usually wide when overall literacy is low, and becomes narrower as 100% literacy is approached.

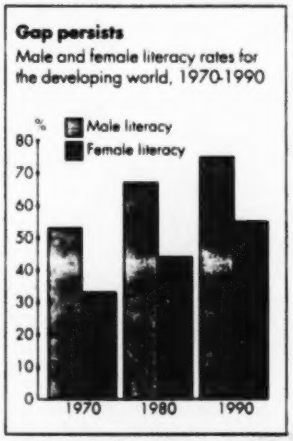
Progress in literacy





SOURCES Before 1961: historical data cited in UNESCO, World literacy at midcentury, 1957; 1961 and later: UNESCO, Compendium of statistics on illiteracy, no. 31, 1990.

The literacy ladder



SOURCE UNESCO, World education reports, 1991 and 1993.

The big 10

Female literacy rates for the 10 most populous countries of the developing world (representing almost three quarters of its total population)

	% women literate 1990
Philippines	93
Mexico	85
Viet Nam	84
Brazil	81
Indonesia	75
China	68
Nigeria	40
India	34
Bangladesh	22
Pakistan	21

SOURCES Literacy: UNESCO, Statistical yearbook 1993. Population: United Nations Population Division, World population prospects: the 1992 revision, 1993.

Catching up

Twelve countries have lifted female literacy by 30 points in 20 years

	% women literate 1970	% women literate 1990	% pt. rise
Saudi Arabia	2	48	46
Jordan	29	70	41
Kenya	19	59	40
Tunisia	17	56	39
Zaire	22	61	39
Libya	13	50	37
Turkey	34	71	37
Algeria	11	46	35
Ghana	18	51	33
Indonesia	42	75	33
Iraq	18	49	31
Syria	20	51	31

SOURCE UNESCO, Statistical yearbooks, 1993 and earlier years.

DISPARITY

The Sudan – one of six countries where 80% or more of girls suffer genital mutilation

Women still mutilated in 28 countries

The genital mutilation of girls is a common practice in 28 African countries and is inflicted on an estimated 2 million young girls each year. In total, WHO calculates that there are over 100 million girls and women in the world today who have suffered female genital mutilation (FGM).

Ranging from circumcision, in which part of the clitoris is removed, to the more extreme forms of excision and infibulation, FGM is not required by any religion; it is inflicted by traditions designed to preserve virginity, ensure marriageability, and suppress female sexuality.

Approximately three quarters of all women mutilated in this way can be found in just five countries – Nigeria, Ethiopia, Egypt, the Sudan and Kenya. In some countries – Djibouti, Somalia, Eritrea, Ethiopia, Sierra Leone and the Sudan – more than 80% of all girls are estimated to suffer genital mutilation, sometimes as early as the age of two.

Apart from the fear and trauma, the immediate consequences of FGM can include death, haemorrhage, tetanus, sepsis, fistula, and HIV. In the longer term, it affects normal sexual functions and reproductive health; it can also lead to bladder and urinary tract infections, difficulty in menstruation, and an increased risk of haemorrhage, infection, and obstructed labour during childbirth.

In seeking ways to end FGM, it is now widely recognized that the lead should be taken by women from societies in which the practice is prevalent. Several African organizations, both governmental and private, are working to educate and persuade women – and, more especially, men – that the practice should be abandoned. Internationally, there is now an Inter-African Committee for the Elimination of Traditional Harmful Practices.

Statistics about FGM are difficult to collect. The following table, prepared in 1993 for WHO, brings together the best available estimates.

75% in five countries

Estimated prevalence of female genital mutilation

	Estimated %	Estimated no (millions)
Nigeria	50	29.2
Ethiopia	90	22.5
Egypt	50	13.5
Sudan	89	11.8
Kenya	50	6.3
Somalia	98	4.6
Côte d'Ivoire*	60	3.8
Mali	75	3.8
Burkina Faso	70	3.4
Ghana	30	2.4
Sierra Leone	90	2.0
Chad	60	1.8
Guinea	50	1.5
Eritrea	90	1.5
Tanzania	10	1.4
Benin*	50	1.2
Togo	50	1.0
Zaire	5	1.0
Central African Rep	50	0.8
Liberia*	60	0.8
Niger*	20	0.8
Senegal	20	0.8
Uganda*	5	0.5
Gambia	60	0.3
Guinea Bissau*	50	0.3
Mauritania*	25	0.3
Djibouti	98	0.2
Cameroon*	—	—

* Anecdotal information only.

[illegible] FGM [illegible] 1993 [illegible] in Maternal and child health and family planning: current needs and future orientation, report to Executive Board, WHO, January 1994. Population: United Nations Population Division, World population prospects: the 1992 revision, 1993.

1 in 6 chance of death

Two indicators which measure progress – or the lack of it – for the poor majority of the world's women are the maternal mortality rate and the prevalence of low birth weight.

The maternal mortality rate is a measure not only of poverty but also of the priority society gives to a problem that is of life-or-death concern to women. A high rate of low-birth-weight babies indicates that a large proportion of pregnant women have suffered from inadequate nutrition and health care during childhood, puberty, and/or pregnancy.

Risking death to give life

Twelve nations have estimated maternal mortality rates of 800 or more. The average rate for Western Europe is 6.

	Maternal mortality (per 100,000 live births)	Lifetime chance of dying in pregnancy or childbirth*
Guinea	800	1 in 15
Nigeria	800	1 in 16
Zaire	800	1 in 16
Burkina Faso	810	1 in 16
Nepal	830	1 in 18
Congo	900	1 in 15
Papua N. Guinea	900	1 in 19
Chad	960	1 in 15
Ghana	1000	1 in 14
Somalia	1100	1 in 11
Bhutan	1310	1 in 11
Mali	2000	1 in 6

* Affected not only by maternal mortality rates but also by the number of births per woman.

Maternal deaths

Maternal death rates for the 10 most populous nations of the developing world

	Maternal mortality (per 100,000 live births)	Lifetime chance of dying in pregnancy or childbirth*
China	95	1 in 400
Philippines	100	1 in 210
Mexico	110	1 in 240
Viet Nam	120	1 in 180
Brazil	200	1 in 150
Indonesia	450	1 in 60
India	460	1 in 45
Pakistan	500	1 in 30
Bangladesh	600	1 in 30
Nigeria	800	1 in 16

Low birth weight

Prevalence of low birth weight in the 10 nations with the largest numbers of births each year (representing almost 60% of all the world's births)

	% babies born below 2.5 kg
United States	7
China	9
Brazil	11
Mexico	12
Indonesia	14
Ethiopia	16
Nigeria	16
Pakistan	25
India	33
Bangladesh	50

Sources: *Maternal mortality*: WHO, Division of Family Health, *Maternal mortality: a global factbook*, 1991. *Total fertility rate*: United Nations Population Division, *World population prospects: the 1992 revision*, 1993. *Low birth weight*: WHO, Maternal Health and Safe Motherhood Programme, *Low birth weight: a tabulation of available information*, 1992.

CHILD RIGHTS

COMMENTARY

There are many who say that the international Convention on the Rights of the Child is just another piece of paper. another list of pious intentions, another example of the international community sinking its gums into the great issues of the day.

But if people and their organizations in all countries continue to mobilize behind the Convention, campaigning to hold 156 governments to their promise, then it will eventually become a standard below which any civilized nation – rich or poor – will be ashamed to fall.

They will not get away with it forever

Stephen Lewis

Stephen Lewis was appointed as a UNICEF Special Representative in 1990 and has become one of the organization's principal spokespersons on children's rights. A former Canadian Ambassador to the United Nations and Special Adviser on Africa to the Secretary-General, he has received many awards for his broadcasting and advocacy work in the field of human rights.

The stories pour forth in an avalanche of horror.

From Bosnia, young girls raped, gang-raped, raped again, mutilated, murdered. From Angola, Cambodia, Afghanistan, Mozambique, children literally torn to shreds by land-mines or, at best, dismembered, consigned to live entire lives as amputees. From Brazil, a paramilitary massacre of street children while they sleep in the quiet shadows of a church. From Thailand, young girls, very young girls, girls who are still pre-pubescent, stolen from their Myanmar villages to be locked in brothels, servicing ten, fifteen, twenty, thirty male sexual predators every 24 hours. From Somalia, Sudan, Rwanda, child refugees on the run, tears and terror intermingled, frantically fleeing civil war, cut down in their flight by mortars, bullets, machetes.

What in heaven's name is happening here? How is it that these incidents are merely examples that can be multiplied in the hundreds of thousands, perhaps millions, without ever the world calling a halt?

It isn't that the crimes against children go unnoticed. The media give them regular, sometimes massive coverage. Whenever there's a particularly grotesque episode, as in the case of a tiny girl injured in a Sarajevo shelling while waiting for transport to an outside hospital, there's a concomitant media frenzy.

It isn't that there aren't a sufficient number of advocates. In every part of the globe, there are non-governmental organizations (NGOs) working every waking hour of the day to document the injustices heaped upon children. They miss almost nothing. They make their case with unanswerable force.

It isn't that there aren't powerful voices within the United Nations system. I won't apologize for special pleading by describing UNICEF as *primus inter pares* in that role. But one should never forget the work of the Human Rights Commission, the Centre for Human Rights, or the experts who report on every conceivable aspect of the abuse of children.

Yet withal, we appear to be moving backwards. If anything, the growing public awareness clashes directly with the growing international reality of violence against children. Something truly awful is happening: by design, by wilful premeditation, by conduct unbecoming in a civilized society, we are actually choosing children as targets. It would seem – and the evidence suggests – that there's an aggravated moral disintegration under way, that we are assaulting children more mercilessly than ever.

The huge question is: will it change, and if so, when? And the answer is, that if there is any real hope, it must lie in the Convention on the Rights of the Child.

The Convention has transformed the struggle around the human rights of children. Every time a country ratifies, new momentum is created. By virtue of public pressure, by virtue of international monitoring, it's simply not possible for a State to ratify and then wash its hands of implementation. A government may get away with it for a while; it will not get away with it forever.

It's fashionable to scoff at these tools of international law. More often than not they don't work. But that isn't true of the Convention on the Rights of the Child. For three reasons, it's different.

First, the rights are indivisible. This is the only international covenant where political, civil, economic, social and cultural rights have identical and equal status.

Second, many of the social and economic rights are already being implemented – health, education, and nutrition, for example. By virtue of the quantifiable goals established by the World Summit for Children, and the National Programmes of Action which, country by country, give expression to those goals, these social and economic rights are not abstractions. They're real. And the fact that they're real can be sustained because the Convention acts as a legal imperative – indeed, as a kind of legislative foundation – for the policies of the countries which have ratified.

Third, and most important, the things we cannot quantify – the physical, emotional and psychological damage done by the sex trade, bonded labour, the streets, violence, armed conflict – are explicitly dealt with. It is the triumph of the Convention on the Rights of the Child that nothing is left out. Its clauses provide uncompromising protection against economic exploitation and sexual exploitation and torture and war and homelessness and every other evil to which the lives of children, in this perverse and brutal world, are subject.

What exactly does that mean? Does it mean that there's an obvious way to stop the carnage? The answer is no. Does it mean that when a country violates international law, it can be hauled up before a court somewhere and forced to comply? The answer is no. Nor does it mean, unfortunately, that there is some form of penalty imposed on countries guilty of practising or tolerating destructive malice against their children.

What, then, is the point of the Convention?

The answer is straightforward: the Convention provides a standard, a benchmark against which the behaviour of nations can be tenaciously and perpetually measured. To be sure, nothing will change overnight. We have never been able to fashion a regimen of international law which holds countries irrevocably accountable. But we can apply such unrelenting pressure that, over time, policies will change and sanity will prevail.

How much time? It matters not so long as we keep hammering away. And that's the beauty of the Convention. There it is – principled, unambiguous, a sacred text for the Rights of the Child. We can nail country policies to the mast; we can label countries as pariahs in the domain of human rights; we can take a given clause of the Convention and rhetorically ram it down the throat of some offending State, or exquisitely employ it to make a persuasive legal argument. One day – not so far off, I judge – rather than using 'democratization' or a 'market economy' as conditions for aid or trade, we will be able to demand respect for the rights of children as the quid pro quo of stable international relationships.

I give it ten years, maybe twenty, and there will come a time when we no longer count the scars and the bodies. Look at Viet Nam: it's reforming its juvenile justice system because of the Convention. Look at Barbados: it passed legislation prohibiting the execution of minors because of the Convention. Look at Namibia: it's written portions of the Convention into its Constitution. Look at Bangladesh: it made schooling compulsory for girls, in part because of the Convention.

Yes, human beings being what we are, it will take time, a long time. But with the appropriate combination of rage and persuasion, we'll transform the condition of children throughout the world.

The Convention on the Rights of the Child says that all children have a right to survival, health care, and education. Progress in these areas is recorded in earlier chapters.

The Convention also demands protection against exploitation and abuse – in the home, at work, and in wars. Monitoring progress in these areas is much more difficult.

Using the limited information available, The Progress of Nations will attempt to document some of the advances and set-backs as the Convention struggles from universal acceptance to universal observance.

CHILD RIGHTS VIOLATIONS

Children at arms – banned by child rights convention

Child rights – 19 nations still to sign

No human rights agreement has ever been ratified so quickly by so many nations as the 1989 Convention on the Rights of the Child. In less than four years, over 150 nations have accepted the document as an internationally agreed minimum standard for the treatment of children. But there are still 19 countries that have neither ratified nor signed the Convention (signing indicates intention to ratify).

In addition to setting out the rights of children to basic health care and education, the Convention seeks to protect the young from abuse, exploitation or neglect at home, at work, and in armed conflicts.

Child wrongs

The following countries had not signed or ratified the Convention on the Rights of the Child as at March 1994

Andorra
Botswana
Brunei
Darussalam
Georgia
Iraq
Kiribati
Kyrgyzstan
Malaysia
Nauru
Oman
Saudi Arabia
Singapore
Solomon Is
Somalia
Tonga
Tuvalu
U. Arab Emirates
United States
Uzbekistan

On the brink

The following 14 countries have signed the Convention – signifying an intention to ratify in the future.

Eritrea
Haiti
Iran
Kazakhstan
Liechtenstein
Mozambique
Netherlands
Qatar
Samoa
South Africa
Swaziland
Switzerland
Turkey

45 nations late in reporting

Nations ratifying the Convention on the Rights of the Child agree to submit a report within two years detailing the steps taken to implement it.

These reports are therefore an early indication of how seriously the Convention is being taken.

By March of 1994, 111 nations were due to have reported and 35 – less than a third – had done so. The following 45 nations are more than one year late in submitting reports.

Angola
Australia
Bahamas
Bangladesh
Barbados
Belize
Benin
Bhutan
Brazil
Burundi
Chad
Côte d'Ivoire
Cyprus
Djibouti
Ecuador
Gambia
Ghana
Grenada
Guatemala
Guinea
Guinea-Bissau
Guyana
Kenya
Korea, Dem
Malawi
Maldives
Mali
Malta
Mauritius
Mongolia
Nepal
Niger
Panama
Portugal
St Kitts/Nevis
Senegal
Seychelles
Sierra Leone
Togo
Uganda
Uruguay
Venezuela
Yugoslavia
Zaire
Zimbabwe

Source: United Nations Office of Legal Affairs and United Nations Centre for Human Rights, March 1994

* Former

NPAs near 100

Ninety-three countries have finalized National Programmes of Action (NPAs) for achieving the goals of the 1990 World Summit for Children.

The goals, to be achieved by 2000, mirror provisions in the Convention on the Rights of the Child and include 90% immunization coverage, halving child malnutrition, primary education for 80%, and safe water and family planning services for all.

The extra cost of reaching the goals is estimated at $25 billion a year – affordable if even 20% of government spending, and 20% of overseas aid, were allocated to basic needs.

The following countries had drawn up NPAs by March 1994.

Sub-Saharan Africa

Benin
Botswana
Burundi
C. African Rep
Chad
Comoros
Congo
Côte d'Ivoire
Gambia
Ghana
Guinea
Kenya
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Senegal
Swaziland
Tanzania
Uganda
Zimbabwe

Middle East and North Africa

Algeria
Bahrain
Djibouti
Egypt
Iran
Kuwait
Morocco
Qatar
Saudi Arabia
Sudan
Syria
Tunisia
Turkey
United Arab Emirates

South Asia

Bangladesh
Bhutan
India
Maldives
Nepal
Pakistan
Sri Lanka

East Asia and Pacific

China
Fiji
Indonesia
Korea, Dem
Korea, Rep
Lao Rep
Mongolia
Myanmar
Philippines
Singapore
Thailand
Viet Nam

Central America and Caribbean

Barbados
Belize
Costa Rica
Cuba
Dominican Rep
El Salvador
Guatemala
Honduras
Mexico
Nicaragua
Panama
Trinidad and Tobago

South America

Argentina
Bolivia
Chile
Colombia
Ecuador
Paraguay
Peru
Uruguay
Venezuela

Industrialized countries

Australia
Belgium
Canada
Denmark
Finland
Germany
Holy See
Japan
Netherlands
Norway
Portugal
Sweden
United Kingdom
United States

Child prostitutes estimated at 100,000 in the Philippines – and the same in Thailand

1 million child prostitutes in Asia

The sexual exploitation of children is now a feature of economic life in several countries of Asia and Latin America. Recent estimates suggest at least 1 million children are involved in eight Asian countries alone.

Definitions of child prostitution vary. Estimates of up to half a million child prostitutes in Brazil, for example, include street children who may sell sex if someone makes an offer: the estimated 1 million child prostitutes of Asia, on the other hand, are mostly in brothels or massage parlours where many are kept in a state that is indistinguishable from slavery.

Many factors are driving the trade, including economic desperation. But in the age of cheap air travel, more and more 'tourists' and businessmen from the industrialized nations, and from other developing countries, are seeking out child prostitutes. Many travel because there is less risk of exposure and jail, or in the hope that sex with young children means less risk of AIDS.

There are no adequately documented statistics on the number of children involved in prostitution. But according to the Thailand-based organization End Child Prostitution in Asian Tourism (ECPAT), there are now as many as 300,000 child prostitutes in India, 100,000 in Thailand, 100,000 in Taiwan, 100,000 in the Philippines, 40,000 in Viet Nam, 30,000 in Sri Lanka, and many thousands in China. An estimated 150,000 Nepali girls under 16 are to be found in Indian brothels – and as many as 40,000 Bengali children are being prostituted in Pakistan.

Germany, Norway and Sweden have introduced new laws to allow the prosecution of child-abusing 'sex tourists' in their country of origin. Australia, France and New Zealand are considering legislation.

Article 34 of the Convention on the Rights of the Child specifically requires ratifying governments to end the exploitative use of children in prostitution or other unlawful sexual practices. No government encourages 'sex tourism'; some do more than others to protect children from it.

Sex tourism: the destinations

Sexual abuse of children by foreign visitors – businessmen or tourists, from inside or outside the region – has been reported in the following countries

Argentina
Bangladesh
Benin
Brazil
Cambodia
Chile
Colombia
Costa Rica
Côte d'Ivoire
Cuba
Dominican Rep.
El Salvador
Guatemala
Guinea
Haiti
India
Indonesia
Kenya
Korea, Rep.
Mali
Mauritania
Mexico
Morocco
Peru
Philippines
Senegal
Sri Lanka
Taiwan
Thailand
Uruguay
Viet Nam
Zaire

[illegible] How many children are in prostitution in Asia [illegible] ECPAT newsletter special edition, July 1993, and International Catholic Child Bureau, unpublished data, 1994.

100 million mines threaten children's lives and limbs

Thousands of children are being killed and disabled by the anti-personnel mines that are waiting in their tens of millions in the earth of 62 countries from Afghanistan to Croatia. Countless others face worsening poverty and starvation because fields that should be providing food and jobs are now sown only with land-mines and yield nothing but death and disability.

Of the 340 different kinds of land-mine being produced by 46 nations, many are designed to shred limbs rather than kill; others contain almost no metal parts and they are virtually undetectable.

No one knows how many mines have been laid and where. The US State Department estimates 85 million. The UN puts the figure at over 100 million. Afghanistan's war has left a legacy of some 9 or 10 million uncleared mines. Angola also has 9 million – as many mines as people – killing 100 Angolans a month. Iraq has 5 to 10 million, Kuwait 5 to 7 million, Cambodia 4 to 7 million, and Mozambique 2 million. During the present conflict in the former Yugoslavia, about a million mines have been laid in Bosnia Herzegovina and another million in Croatia.

Another 10 million mines are being manufactured annually to feed the $200-million-a-year trade. Mine scattering equipment and minefield clearance services – often provided by the same companies – are even bigger business.

The UN is currently involved in mine clearance schemes in seven countries. But the job is slow, difficult, and expensive: the mines cost as little as $3 each to make – but $300 to $1000 each to find and make safe.

As well as trying to help thousands of children whose lives and limbs have been shattered by anti-personnel land-mines, UNICEF's Executive Director has called for a complete worldwide ban on their production, stockpiling, use, sale and export.

To date, three industrialized countries – Belgium, France, and the United States – have ordered a national moratorium on the export of anti-personnel land-mines.

Exporters...

The following countries produce land-mines. Nations in bold type are, or have recently been, exporters.

Argentina
Austria
Belgium
Brazil
Bulgaria
Canada
Chile
China
Cyprus
Czechoslovakia*
Denmark
Egypt
El Salvador
France
Germany
Greece
Hungary
India
Iran
Iraq
Israel
Italy
Japan
Korea, Dem.
Korea, Rep.
Mexico
Netherlands
Nicaragua
Pakistan
Peru
Poland
Portugal
Romania
Singapore
South Africa
Soviet Union*
Spain
Sweden
Switzerland
Taiwan
U. Kingdom
United States
Venezuela
Viet Nam
Yugoslavia*
Zimbabwe

* Former

[illegible] Arms Project of Human Rights Watch and Physicians for Human Rights, Landmines: a deadly legacy, Human Rights Watch, October 1993.

...Importers

Lifelong disability is the price paid by tens of thousands of children who survive land-mine explosions.

THE INDUSTRIALIZED

COMMENTARY

Progress for children in the industrialized world can no longer be taken as a given.

Today, there are many millions of children in economically advanced nations whose quality of life would have to be judged poorer than that of many children in the developing world.

For many people in many nations, it is the United States that defines the idea of life in an advanced industrial state.

Here, Marian Wright Edelman lists the symptoms and looks at the causes of a growing crisis for America's children.

This is not who we are

Marian Wright Edelman

Marian Wright Edelman is the President of the Children's Defense Fund, based in Washington, D.C. She began her work for children in the mid-1960s with the NAACP Defense and Educational Fund, a civil rights group. Since founding the Children's Legal Defense Fund in 1973, she has achieved wide recognition as a spokesperson on behalf of American children and families.

Across much of the world today there is an evident will to pursue the path of progress that has been pioneered by the United States of America. As an American, I am well aware that there is much to admire about my own country and its achievements. But I also know that there is much that is not worthy of emulation.

In particular, I do not think that any country would wish to emulate the way that America, as a society, is treating its children. One in five of those children is today living in poverty. Eight million of those children lack health coverage. Three of every 10 are born into a single-parent family. About 3 million a year are reported to be neglected, or physically or sexually abused – triple the number in 1980.

These rising indicators of social distress are now accompanied by an unprecedented upsurge in violence by and against children and young people. The overall murder rate of young people is seven times higher than in any Western European country. Every two days, the equivalent of a whole classroom full of young children dies by the bullet.

Violence *by* young people is rising equally steeply. Arrests of juveniles for murder and non-negligent manslaughter doubled in the 1980s.

No place in society

Such trends cannot, of course, continue. For they are carrying America to the brink of social and economic disintegration.

No longer are the problems of endemic poverty, joblessness, family disintegration, domestic violence, racial intolerance, teenage pregnancy, and drug abuse just problems that happen to other people. Today, almost everyone is affected. Even a white middle-class child knows that we are a nation in crisis. We have lost the feeling that generations of Americans have always held dear – that the future will be a bright one. The American dream is fading for too many American children.

When we Americans ask why this is happening, in the richest and most advantaged country on earth, many of us know that at bottom, the fault lies in the kind of values and the kind of progress we have been pursuing.

We know that we have oversold ourselves and our young people on one dominant aspect of our culture – its material success. By advertising and by example, we have communicated to our young people that to be admired and respected they must have particular and ever-changing possessions and lifestyles. Yet at the same time as parading before them these material definitions of success, we have denied to too many the legitimate means of achieving them – the education, the skills, the jobs and the opportunities.

As a result, many millions of our young people feel that they have no economic and social place in our society, that they have little to respect in themselves or to be respected for by others. And from this point of alienation and frustration, the path to drugs, alcohol abuse, crime, violence, and prison is ever open.

In the last decade, these tensions have been heightened by policies that have deepened the divide between rich and poor and further exalted the material definition of success and purpose. Since 1980, the poor in America have seen their real incomes fall substantially. Safety nets have been dismantled, and an underclass has been created, white as well as black, so that there are today approximately 5 million more American children living in poverty than there were in 1973.

No civilized society, no democracy, no capitalism, can survive long under the strains arising from the frustrations, injustices, divisions and inequalities that we have created.

Under pressure from all of these forces, we are witnessing a breakdown in American values, in our common sense and community responsibility, and especially in our responsibility to protect and nurture our children. We are losing our sense of meaning, failing to find our sense of purpose in family, or community life, or in faith. We are dying spiritually. That is why the dream is fading. That is what is tearing the heart out of America today. And somehow we must find a way to teach our children that there is something better. We must cry out to them that this is not who we are.

Back from the brink

If we are to pull back from the brink, then we need to acknowledge that the epidemic of violence and social disintegration that threatens to overwhelm our society is the result of policies that have favoured the rich over the poor, and material values over human and spiritual values. Above all, we need to acknowledge that what we are now seeing is the result of years of neglect and lack of investment in our children.

To reverse the decline, we must first of all create jobs.

There is plenty of work to be done if we are to meet human needs, extend community programmes, and improve our social and physical environment. And there are many who need that work to enable them to earn a livelihood, to take back their dignity, and to fulfil their responsibilities as parents.

As well as jobs that are created by economic growth, we need to create at least a million new jobs targeted primarily to young people in poor rural and inner-city areas. We must also build on the many, many good examples of educational initiatives that work, of community outreach projects, of programmes to prevent teen pregnancy, of efforts which offer skills and opportunities and hope. And we must build on them not here and there, piecemeal, but on a national scale.

Enemy within

To do this, we will have to refute the argument that government cannot afford to make such investments.

What we cannot afford is to spend $274 billion a year on external defence when the real enemy is within. What we cannot afford is $6 billion for a new Sea Wolf submarine, and $25 billion for a new F-22 fighter, while denying our children decent health, education, opportunity, and hope. If we are to keep the dream alive, if we are to offer hope and self-respect to our young people, then we have no greater priority than renewing investment in jobs, in health, in education, in our children's and our nation's future.

Today, with new national leadership, a beginning has been made. We have the Family and Medical Leave Act, an expanded Earned Income Tax Credit to help lower-income working families, a Hunger Relief Act, and a $1 billion Family Preservation Programme.

But no President can do this job alone. No Congress can do it alone. We must also confront the problem of child neglect in our homes, in our families, in our communities, and in our justice system. This has to be the responsibility of every family, every community, every faith, every neighbourhood, every American.

Every one of us is responsible. It is time to begin salvaging our ideals.

The 1994 State of America's children report is available from the Children's Defense Fund, 25 E Street, N.W. Washington, DC 20001, USA.

Significant numbers of children in the rich world live in poverty – approximately 5% in much of Western Europe, 10% in Australia, Canada and the UK, and 20% in the United States.

Murder of and suicide by young people has been steadily increasing in almost all industrialized nations.

Child abuse and neglect, though difficult to measure, also appears to be rising. An estimated 10% – 15% of children in industrialized nations are sexually abused.*

* Source: Marc A. Belsey, 'Child abuse: measuring a global problem', World health statistics quarterly, vol. 46, 1993

Child abuse – notoriously difficult to measure

New child abuse index proposed

Spain and Italy have the lowest reported incidence of child abuse in the industrialized world, according to an initial attempt by WHO to construct an international child abuse index.

Abuse and neglect of children appears to be a major problem in almost all countries – poor as well as rich. But it is notoriously difficult to measure. Some countries keep national child abuse registers based on cases reported and investigated; and some health services also screen children for possible cases of abuse or neglect. But different definitions and reporting systems make international comparison hazardous. Even where statistics do exist, there is always a question mark over whether higher figures in one country simply reflect more openness about the subject and more reliable systems of reporting.

WHO's proposed index goes some way towards resolving this problem by counting only those cases of abuse and neglect that result in death – a category for which more dependable statistics are available. But rather than accepting only proven cases of child homicide, WHO suggests totalling child deaths from two internationally standardized categories – homicide and 'deaths from undetermined external causes'. This total, when translated into a rate per 100,000 births, is suggested as a first step towards an internationally accepted indicator of child abuse and neglect.

The indicator has weaknesses, as WHO points out. First, infant deaths represent only the tip of the abuse and neglect iceberg. Second, most abused children are not infants but two-to-four-year-olds (at the moment, internationally comparable statistics are only available for children under one year). Third, not all deaths from 'undetermined external causes' are a result of physical abuse. But, says WHO, "the reporting patterns appear consistent over time, and the grouping of homicides and deaths due to undetermined causes appears to give a more consistent pattern for comparison among countries."

The following table shows the new 'neglect and abuse death rate' for infants under one in 23 industrialized nations.

Presumed guilty

Deaths of infants from presumed abuse per 100,000 live births, 1985-1990

Czechoslovakia*	10.1	Belgium	4.3
United States	9.8	United Kingdom	3.9
Soviet Union*	8.7	Germany	3.5
Denmark	8.1	France	3.1
Japan	7.4	Canada	2.7
New Zealand	6.9	Poland	2.4
Finland	6.2	Netherlands	2.1
Hungary	5.7	Norway	1.7
Australia	5.5	Sweden	0.9
Switzerland	4.9	Italy	0.4
Bulgaria	4.7	Spain	0.2
Austria	4.3		

* Former

Source: Marc A. Belsey, 'Child abuse: measuring a global problem', World health statistics quarterly, vol. 46, 1993

Five of the best

Austria, Denmark, Finland, Norway and Sweden have already passed laws forbidding all forms of physical punishment of children – whether in homes, schools, or juvenile correction institutions. In addition to these five, at least six more countries are now considering similar legislation – Canada, Germany, Ireland, New Zealand, Poland, and Switzerland.

Governments that have ratified the Convention on the Rights of the Child are obliged to protect children from "all forms of physical or mental violence." So is the smacking of children a violation of the Convention on the Rights of the Child? Yes, says the UN Committee on the Rights of the Child.

In some nations, the issue of physical punishment of children remains controversial. In others the issue was settled long ago: Austria and Finland banned physical punishment in schools a hundred years ago.

Is physical punishment illegal?

	Homes	Schools	Juvenile correction systems
Albania	No	Yes	Yes
Australia	No	No*	No
Austria	Yes	Yes	Yes
Belgium	No	Yes	Yes
Canada	No	No	Yes
Denmark	Yes	Yes	Yes
Finland	Yes	Yes	Yes
France	No	Yes	Yes
Germany	No	Yes	Yes
Greece	No	Yes	Yes
Hungary	No	Yes	Yes
Ireland	No	Yes	Yes
Israel	No	Yes	Yes
Italy	No	Yes	Yes
Japan	No	Yes	No
Luxembourg	No	Yes	Yes
Netherlands	No	Yes	Yes
New Zealand	No	Yes	Yes
Norway	Yes	Yes	Yes
Poland	No	Yes	No
Portugal	No	Yes	Yes
Romania	No	Yes	No
Spain	No	Yes	Yes
Sweden	Yes	Yes	Yes
Switzerland	No	Yes	Yes
United Kingdom	No	Yes*	Yes
United States	No	No*	No*

* AUSTRALIA: prohibited in some states. CANADA: prohibited in British Columbia. UNITED KINGDOM: allowed in private schools. UNITED STATES: some states prohibit in public schools, residential institutions, foster care, and day care centres.

Source: Epoch Worldwide and National Committees for UNICEF

DISPARITY

Europe has street child too

Child poverty league

The proportion of a nation's children living below the poverty line is or should be a litmus test of national progress. Yet the latest internationally comparable figures for child poverty in the industrialized nations date back to the mid-1980s.

One small research project – the Luxembourg Income Study (LIS) based at Syracuse University, USA – is attempting to put this right by monitoring household incomes in some 20 industrialized nations. The table below summarizes the results of LIS inquiries into changes in child poverty levels over the period 1979-1981 to 1985-1987 in eight nations with comparable data. By 1995, LIS hopes to publish new figures bringing the child poverty record into the early 1990s. Watch this space.

Child poverty

Percentage of children living below the poverty line in the mid-1980s. The poverty line is defined here as family income below 40% of median national income – after taking into account the effects of tax and benefit policies.

	% living below poverty line	
United States	14.7 (1979)	20.4 (1986)
Canada	10.2 (1981)	9.3 (1987)
Australia	8.6 (1981)	9.0 (1985)
United Kingdom	–	7.4 (1986)
France	4.7 (1979)	4.6 (1984)
Netherlands	4.0 (1983)	3.8 (1987)
Germany	1.3 (1981)	2.8 (1984)
Sweden	2.1 (1981)	1.6 (1987)

[illegible] Smeeding [illegible] Challenge January/February 1992

Teen suicides fall in Eastern Europe

While most industrialized countries have seen the level of teenage suicide holding steady or increasing over the last two decades, two Eastern European countries have seen a sharp fall. Suicide among young people in Hungary has almost halved, while in Czechoslovakia (now the Czech Republic and Slovakia) the rate fell by nearly 60%.

Meanwhile, suicide by teenagers (15-19) has increased significantly in Canada, Ireland, New Zealand, Norway, Spain, the United Kingdom, and the United States.

Norway shows by far the biggest increase in rate over the period, but the absolute numbers are so small that the increase in rate can be exaggerated by small annual variations in the particular years chosen for comparison. The same is true of Ireland, which has also seen a large rise in its teen suicide rate – again from a low and perhaps underreported base in 1970. Of the major industrial powers, Japan is the only one to record a substantial fall.

Approximately four times as many teenage boys commit suicide as girls.

Teenage suicide

Suicides of young people aged 15-19, annual number and rate (per 100,000 in age group)

Current rate higher than 10

	Rate per 100,000 1970	Rate per 100,000 1991	No. 1991
New Zealand	5.8	15.7	45
Finland	10.6	15.0	46
Canada	7.0	13.5	253
Norway	1.3	13.4	41
United States	5.9	[illegible]	1979
Australia	5.5	10.5	143
Austria	13.4	10.2	52

[illegible] WHO unpublished data

Current rate 5 to 10

	Rate per 100,000 1970	Rate per 100,000 1991	No. 1991
Hungary	15.0	8.4	70
Czechoslovakia	18.3	7.7	102
Ireland	0.4	7.5	26
Bulgaria	5.9	7.2	48
Poland	7.0	7.1	210
Switzerland	8.6	6.7	28
Sweden	7.6	6.2	35
France	5.5	5.3	217

* Former

Current rate less than 5

	Rate per 100,000 1970	Rate per 100,000 1991	No. 1991
Denmark	2.4	4.4	16
United Kingdom	2.3	4.3	159
Japan	7.8	3.8	371
Portugal	4.1	3.7	31
Netherlands	2.4	3.1	32
Spain	1.1	3.1	102
Italy	2.4	2.5	109
Greece	1.4	1.3	9

Former Soviets high in murder league

The United States has a teenage murder rate seven times higher than any Western European nation, according to new figures from WHO. In total, over 3000 teenagers (15 to 19) were murdered in the United States in 1991, as opposed to fewer than 300 in the whole of Western Europe.

After the United States, the next eight places in the teenage murder league are occupied by former Soviet Republics.

In most countries, the differences between 1970 and 1990 figures are so small that no general trend can be deduced. But among the countries with larger numbers, the rate has doubled in Bulgaria, Canada, and the United States, and tripled in Italy. In five countries – including Japan and the United Kingdom – the rate has actually dropped over the last two decades. Most teen murder victims are male.

Teenage murders

Homicides against young people aged 15-19, annual number and rate (per 100,000 in age group)

Current rate higher than 3

	Rate 1970	Annual rate 90-91	Annual no. 90-91
United States	8.1	15.9	3020
Russian Federation	–	10.2	1052
Kazakhstan	–	7.8	114
Kyrgyzstan	–	6.1	26
Belarus	–	5.4	39
Ukraine	–	5.3	195
Lithuania	–	4.4	12
Latvia	–	3.9	7
Armenia	–	3.4	9

[illegible] WHO unpublished data

Current rate 1 to 3

	Rate 1970	Annual rate 90-91	Annual no. 90-91
Bulgaria	1.5	3.0	20
Canada	1.0	2.3	43
Finland	2.1	2.3	7
Italy	0.6	2.1	92
New Zealand	0.4	2.1	6
Australia	1.0	1.8	25
Israel	–	1.6	7
Czechoslovakia*	0.8	1.5	20
Poland	1.1	1.2	34
Denmark	0.3	1.1	4
Germany	–	1.0	43

* Former

Current rate less than 1

	Rate 1970	Annual rate 90-91	Annual no. 90-91
Greece	0.2	0.9	6
Austria	1.5	0.8	4
Netherlands	0.6	0.8	8
Portugal	0.4	0.8	7
Switzerland	0.2	0.7	3
United Kingdom	0.8	0.7	27
Spain	0.4	0.5	10
Sweden	0.7	0.5	3
France	0.3	0.4	17
Ireland	0.0	0.3	1
Japan	0.4	0.3	34
Norway	0.3	0.3	1
Hungary	1.3	0.2	2

In the family, many children's lives are emptying of close relations as family size falls, divorce rates rise, and parents spend more time outside the home.

In the economic environment, children are in the front line of the difficult transitions being made – especially but not exclusively in Eastern Europe.

In the physical environment, children are the most vulnerable to adult mistakes.

These pages also look at the record in giving aid to countries whose environmental problems arise from too little rather than too much.

In the real world, one parent often missing

20% in single-parent families

A quarter of all children in some industrialized countries are growing up in single-parent families. The average is about 20%, with Germany and Italy reporting figures of less than 10% in the 1990s.

Debate continues about the significance of the rising number of children in single-parent families; most would agree that one good parent is better than two bad ones – and can be much better than having one good parent and one bad. But what is not in doubt is the close and consistent connection, in all industrialized nations, between growing up in a single-parent family and growing up in poverty.

One-parent families

One-parent households with children under 15 as a percentage of all households with children under 15

	About 1981	About 1991
United States	–	25*
New Zealand	18	24*
United Kingdom	14	21*
Canada	17*	20*
Norway	17	19
Australia	13	18
Sweden	–	18
Denmark	18	16
Finland	–	14
Netherlands	8	12*
Germany	10	9
Italy	7	5

* CANADA: families with children under 18. NETHERLANDS: 1987 data. NEW ZEALAND and UNITED KINGDOM: households with children under 16 or up to 18 if in full-time education. UNITED STATES: households with children under 18.

Source: 1991: National Committees for UNICEF; 1981: United Nations Demographic Yearbook 1987.

Statistics begin to show Eastern Europe's pain

The human cost of the political and economic transition in Eastern and Central Europe is beginning to show up in social statistics – tracked by the UNICEF International Child Development Centre in Florence.

Albania, Bulgaria, Romania, Ukraine, and the Russian Federation are hardest hit. Adult death rates have risen, secondary school enrolments have declined, and there has been an unprecedented rise in crime rates.

In the Russian Federation, the rise in the overall death rate means that over half a million more Russians died in 1993 than in 1989. The increase has been greatest among adult males.

Central Europe is faring slightly better: the Czech Republic is slowly returning to more normal conditions; Poland is showing early signs of recovery after a sharp drop in living standards; and Hungary, despite a rise in death rates, has managed to hold most other social indicators steady.

So far, the impact on salient indicators of child well-being – under-five mortality rates, immunization levels, and primary school enrolments – has been relatively small in most countries of the region. But the much grimmer statistics of economic decline – falling real wages, rising unemployment, and sharply increasing health care costs – suggest that the environment in which millions of children are growing up has deteriorated more sharply than is captured in the statistics to date.

Some of the main findings (1989-1992) of the UNICEF study:

› Under-five mortality rates have held steady in most countries, declining slightly in Hungary, Poland and Romania and rising in Bulgaria (from 18 to 20 per 1000 births) over the period 1989 to 1992. Infant mortality is actually down slightly in five out of the nine countries.

› Immunization levels have been maintained at over 90% in most countries – a significantly higher average than any other region of the world. The only major exception is the Russian Federation, where measles coverage has fallen from 82% to 62%.

› Near-universal primary school enrolment has also been maintained across the region except in Romania (down from 97% to 94%) and Bulgaria (down from 96% to 89%).

› Enrolment in kindergartens has dropped by 15 – 20% throughout the region (except in Hungary).

› Average life expectancy has declined slightly in all countries of the region except Romania, and by a full two years for Russian men.

› Marriage rates and birth rates have dropped sharply in all Eastern and Central European countries for which figures are available.

› Family and maternity allowances have shrunk faster than pensions.

› Per capita consumption of meat and fish products has fallen in all countries – and the fall has been most severe among the poorest groups.

› Convictions of young people for criminal offences have doubled in Poland and increased by 50% in the Russian Federation.

› Public expenditures on health and education as a percentage of GDP have increased quite sharply in the period 1989-1992 in all Eastern and Central European countries except the Russian Federation. But as real budgets shrink, wages account for a larger share of budgets, operating funds are reduced, and there has been a deterioration in the quality of health and education services.

Dwindling pay

1992 per capita income as a percentage of 1989 per capita income

	%
Bulgaria	61
Russian Federation	62
Poland	70
Romania	89
Hungary	92
Czech Republic	94
Ukraine	96

Source: UNICEF International Child Development Centre, Central and Eastern Europe in transition: public policy and social conditions. Regional monitoring report no. 1, 1993.

DISPARITY

Green hills far away – a grim legacy for children of the industrialized world

How green is my country

Austria, Portugal and Japan lead the industrial nations in environmental protection, according to a report by the London-based New Economics Foundation, a policy think-tank.

Using data mainly from the 1990s, the report looks at the environmental record of the established industrial nations under 11 different headings – including pollutants emitted per capita, water use and quality, nitrate fertilizer use, percentage of native species threatened, percentage of land within protected areas, municipal waste and car travel per person, and energy use per $1000 of GDP. Each country is rated on a scale of 0 to 100, with the best country pegged at 100 and the worst at 0. All scores are then averaged to give each country's overall position in the 'green league table'.

As its authors acknowledge, the 'green index' is a first attempt – and suffers from a number of problems. Portugal ranks in second place, for example, largely because of its relatively low level of GNP and industrial activity rather than any particular verdancy in government policy.

A further problem is that the averaging of the 11 different elements arbitrarily gives them an equal weighting.

Moreover, the decision to award a maximum score of 100 to the best-performing country in each category means that the index is not related to any ideal standard or to what may be required for long-term sustainability. High marks indicate only that a country is performing better than other countries.

Nonetheless, the index is the boldest attempt so far to compare the environmental credentials of the established industrialized nations. And as protecting children clearly means protecting the environment in which they are growing up, and the world they will inherit, the green league table is reproduced here.

Green league

Environmental ratings out of 100 for 20 industrialized nations

	Overall score
Austria	76
Portugal	73
Japan	72
Spain	71
Italy	67
Norway	67
Switzerland	66
Sweden	65
United Kingdom	64
Denmark	63
France	63
Germany	60
Greece	58
Ireland	54
Netherlands	53
Finland	51
Australia	48
Belgium	48
Canada	37
United States	35

[illegible] New Economics Foundation, A green league of nations: relative environmental performance in OECD countries, 1993.

Scandinavians widen gap at top of aid league

A wide gap has opened up between the most generous aid givers and the rest of the industrialized nations. Norway, Sweden and Denmark all gave more than 1% of GNP in aid during 1992, the latest year for which figures are available. Apart from the Netherlands, no other OECD country reached even the 0.7% aid target agreed to in the 1960s. The average for the industrialized nations was 0.34% of GNP.

Judged by aid given per person per year, the Scandinavian countries maintain their clear lead, with the Norwegians, Swedes and Danes giving approximately twice as much per person as the French, Germans or Canadians, three times as much as the Japanese, four times as much as the Italians, five times as much as the British, and six times as much as the Americans.

If all countries were to reach the target aid figure of 0.7% of GNP, an additional $67 billion a year would be made available – more than enough to eradicate the worst aspects of world poverty within a decade.

Recent opinion polls in 11 European countries show that a significant majority of voters are in favour of increasing aid levels (see last column of table). Survey results in Japan, Canada, Sweden and the United States are not comparable – as respondents were also asked if they supported *maintaining* or increasing aid levels. In Japan, over 80% answered 'yes' to this question. In Sweden, 53% were in favour – sharply down from the figures recorded in the 1980s. In Canada, over 50% approved of maintaining or increasing aid.

Surveys in the United States tell a different story. Only 43% want the USA to supply aid at all. Support is weakest among young Americans: only 34% of those under 30 approve of economic assistance.

The aid gap

	Aid as % of GNP 1992	Total aid ($ billions) 1992		Aid per person ($) 1992			% in favour of increasing aid 1991
		Actual	Total if 0.7% of GNP	Actual	Total if 0.7% of GNP	Difference	
Norway	1.11	1.2	–	288	180	+108	63
Sweden	1.05	2.5	–	270	189	+81	–
Denmark	1.04	1.4	–	250	182	+68	80
Netherlands	0.88	2.7	–	167	144	+23	75
France	0.61	7.8	8.9	132	157	–25	60
Finland	0.55	0.6	0.8	141	163	–22	–
Switzerland	0.46	1.1	1.7	160	256	–96	–
Canada	0.44	2.5	3.9	96	145	–49	–
Portugal	0.41	0.3	0.5	25	52	–27	75
Belgium	0.40	0.8	1.5	79	147	–68	53
Germany	0.38	7.0	13.0	109	161	–52	67
Italy	0.35	4.1	8.3	68	144	–76	69
Australia	0.32	1.0	2.1	58	119	–61	–
Japan	0.32	11.1	24.6	83	197	–114	–
United Kingdom	0.31	3.1	7.2	54	124	–70	70
Austria	0.30	0.5	1.2	64	157	–93	–
Spain	0.28	1.5	3.8	36	98	–62	78
New Zealand	0.24	0.1	0.3	30	83	–53	–
United States	0.18	10.8	41.3	45	162	–117	–
Ireland	0.16	0.1	0.3	18	86	–68	69

[illegible]

Sources: Aid: OECD, *Development cooperation*, 1993. GNP: World Bank data, 1994 [illegible] 1993. Public opinion polls: *Eurobarometer* 36 and Norwegian Social Science Data Service, September 1991.

LESS POPULOUS COUNTRIES

The main indicators used to construct the league tables in *The Progress of Nations 1994* include the use rate for oral rehydration therapy, the percentage of girls reaching grade 5 of primary school, female literacy as a percentage of male, and the family planning rate. Using these same indicators, the following table shows the progress of those countries with populations of less than 1 million. The relative standing of these less populous countries can be assessed by comparing the figures given here with the relevant league tables.

The tables also give each country's per capita GNP, total population, under-five mortality rate, percentage of children underweight, percentage of all children reaching grade 5, measles immunization rate, total fertility rate, and maternal mortality rate – enabling comparisons to be made with the statistical profiles on pages 52 and 53.

	% ORT use 1989-92	% children reaching grade 5 1986-92		% using family planning 1981-92	Female literacy as % of male 1970-90	% of 1-year-old children immunized against measles 1992	Population (thousands)		Annual no. of births (thousands) 1992	Annual no. of under-5 deaths (thousands) 1992	Under-5 mortality rate 1992	GNP per capita ($) 1992	% of under-5 children under-weight 1976-90	Total fertility rate 1992	Maternal mortality rate 1980-91
		All	Girls				Total	Under 16							
Antigua/Barbuda	50	-	-	39	-	87	66	30	1.1	0.0	25	4870	10	1.9	-
Bahamas	54	100	100	-	-	93	264	81	5.2	0.2	29	12020	-	2.0	69
Bahrain	73	78	81	54	69	87	533	199	14.1	0.2	16	7130	-	3.8	34
Barbados	15	80	83	-	99	90	259	67	4.1	0.0	12	6530	5	1.8	27
Belize	65	68	66	47	91	72	198	87	7.2	0.4	52	2210	-	4.8	19
British Virgin Islands	-	-	-	-	98	99	17	-	0.3	0.0	33	8500	-	-	-
Brunei Darussalam	-	74	72	-	69	99	270	95	6.5	0.1	10	20760	-	3.1	-
Cape Verde	5	60	60	15	-	82	384	176	13.8	0.8	60	850	19	4.3	107
Comoros	70	29	31	-	40	32	585	297	28.7	3.7	130	510	-	7.1	500
Cook Islands	8	-	-	50	-	87	17	-	0.4	0.0	28	1550	-	3.5	46
Cyprus	4	81	83	-	91	74	716	196	12.3	0.1	11	9820	-	2.3	-
Djibouti	56	38	34	-	-	83	467	222	21.9	3.5	158	1210	23	6.6	740
Dominica	50	100	95	49	94	98	72	27	1.5	0.0	22	2520	4	3.0	58
Equatorial Guinea	40	-	-	-	37	66	369	166	16.2	3.0	182	330	-	5.9	430
Fiji	16	87	84	32	74	91	739	291	17.6	0.5	29	2010	-	3.0	90
Gambia	48	50	38	-	16	83	908	420	40.3	8.8	220	390	-	6.1	1500
Grenada	70	-	-	54	98	73	91	34	2.2	0.1	35	2310	-	3.1	100
Guyana	15	97	99	-	95	76	808	281	20.7	1.3	65	330	22	2.6	200
Iceland	-	-	-	-	-	99	260	68	4.5	0.0	7	23670	-	2.2	0
Kiribati	85	90	92	28	-	77	74	30	2.4	0.2	81	700	-	4.3	10
Luxembourg	-	99	100	-	-	80	378	70	4.7	0.1	11	35260	-	1.6	0
Maldives	27	-	-	-	91	98	227	106	8.8	0.7	78	500	-	6.2	400
Malta	-	100	99	-	86	80	359	88	5.5	0.1	11	7280	-	2.1	0
Marshall Islands	-	-	-	27	-	86	49	-	1.4	0.1	92	*	-	7.2	109
Micronesia, Fed. States	-	-	-	-	-	88	109	49	3.7	0.4	29	*	-	4.8	83
Montserrat	-	-	-	53	97	100	11	4	0.2	0.0	15	3330	-	2.5	-
Palau	-	-	-	38	-	94	16	-	0.5	0.0	35	790	-	4.2	-
Qatar	20	56	60	32	72	79	453	141	10.4	0.3	33	16240	-	4.4	9
Saint Kitts and Nevis	5	88	88	41	98	99	42	13	0.8	0.0	42	3990	-	2.7	150
Saint Lucia	75	96	95	47	82	97	137	63	3.8	0.1	21	2900	14	3.3	26
Saint Vincent/Grenadines	98	-	-	58	96	100	109	39	2.4	0.1	25	1990	-	2.6	13
Samoa	50	-	-	21	-	91	158	67	5.2	0.3	58	940	-	4.7	400
Sao Tome and Principe	50	88	87	10	42	61	124	49	4.5	0.4	85	370	17	5.1	79
Seychelles	88	93	-	-	60	92	72	26	1.6	0.0	20	5480	6	2.9	60
Solomon Islands	60	88	-	25	-	74	342	163	12.9	0.4	34	710	-	5.4	10
Suriname	-	99	100	-	95	84	438	157	11.4	0.4	35	3700	-	2.7	89
Swaziland	85	76	78	21	65	85	792	367	29.6	3.2	107	1080	10	5.0	110
Tonga	30	84	75	39	95	90	97	40	2.9	0.1	25	1350	-	4.1	37
Turks and Caicos Islands	-	-	-	-	98	59	13	-	0.2	0.0	31	780	-	-	-
Tuvalu	-	69	61	-	-	63	12	-	-	0.0	56	650	-	-	460
Vanuatu	66	61	60	15	48	74	157	70	6.0	0.5	85	1220	20	5.7	107

*GNP estimated range $676 – $2695

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NATIONAL PERFORMANCE GAPS

The following tables provide additional statistical information on the progress of nations.

Pages 48 and 49 show the national performance gaps, for all countries, in child survival, child nutrition, and primary education. The national performance gap is the difference between the actual level of progress achieved and the expected level of progress for each country's per capita GNP.

Pages 50 and 51 of this year's edition attempt to show, for all countries, the annual rate of progress in extending immunization against measles, the most important of the vaccine-preventable diseases of childhood.

Pages 52 and 53 present a basic social profile of each nation, and list the social development goals that have been adopted for 1995 and the year 2000.

The tables on these pages show each country's national performance gap in the areas of child survival, nutrition, and education.

The national performance gap is the difference between a country's actual level of progress and the expected level for its per capita GNP.

For each indicator, the expected level of achievement has been calculated from the per capita GNPs and the relevant social indicators of all countries (see opposite). The expected level therefore represents the level that the average-performing country could be expected to have reached for its level of GNP per capita.

SOCIAL INDICATO

NATIONAL PERFO

	GNP per capita 1992	Under-five mortality rate 1992			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
SUB-SAHARAN AFRICA										
Angola	-	-	-	**-**	34	-	**-**	-	-	**-**
Benin	410	-	-	**-**	37	50	**-13**			**-**
Botswana	2790	58	33	**-25**	84	88	**-4**	15	13	**-2**
Burkina Faso	290	150	149	**-1**	24	42	**-18**	-	-	**-**
Burundi	210	179	171	**-8**	45	35	**+10**	18	15	**-3**
Cameroon	820	117	79	**-38**	56	59	**-3**	14	19	**+5**
Central African Rep.	410	-	-	**-**	43	52	**-9**	-	-	**-**
Chad	220	-	-	**-**	45	38	**+7**	-	-	**-**
Congo	1030	-	-	**-**	72	72	**0**	24	16	**-8**
Cote d'Ivoire	670	-	-	**-**	34	41	**-7**	12	19	**+7**
Eritrea	110	-	-	**-**	-	-	**-**	-	-	**-**
Ethiopia	110	208	215	**+7**	11	26	**-15**	48	43	**-5**
Gabon	4450	-	-	**-**	50	90	**-40**	-	-	**-**
Ghana	450	170	120	**-50**	62	52	**+10**	27	26	**-1**
Guinea	510	-	-	**-**	19	55	**-36**	-	-	**-**
Guinea-Bissau	210	-	-	**-**	20	35	**-15**	23	37	**+14**
Kenya	330	74	141	**+67**	67	46	**+21**	14	29	**+15**
Lesotho	590	-	-	**-**	57	58	**-1**	16	30	**+14**
Liberia	450	217	120	**-97**	-		**-**	20	24	**+4**
Madagascar	230	168	165	**-3**	34	40	**-6**	33	32	**-1**
Malawi	210	226	171	**-55**	27	37	**-10**	27	35	**+8**
Mali	300	220	147	**-73**	16	43	**-27**	31	29	**-2**
Mauritania	530	-	-	**-**	60	55	**+5**	48	24	**-24**
Mauritius	2700	24	34	**+10**	89	87	**+2**	24	14	**-10**
Mozambique	60	-	-	**-**	21	8	**+13**	-	-	**-**
Namibia	1610	79	47	**-32**	53	80	**-27**	26	14	**-12**
Niger	300	320	147	**-173**	23	44	**-21**	36	30	**-6**
Nigeria	320	191	143	**-48**	55	44	**+11**	36	30	**-6**
Rwanda	250	222	159	**-63**	60	39	**+21**	29	32	**+3**
Senegal	780	145	83	**-62**	41	54	**-13**	22	20	**-2**
Sierra Leone	170	-	-	**-**	-	-	**-**	29	37	**+8**
Somalia	150	-	-	**-**	3	28	**-25**	-	-	**-**
South Africa	2670	70	34	**-36**	-	-	**-**	-	-	**-**
Tanzania	110	176	215	**+39**	22	22	**0**	29	43	**+14**
Togo	400	137	128	**-9**	77	[illegible]	**+17**	24	25	**+1**
Uganda	170	185	185	**0**	-	-	**-**	23	38	**+15**
Zaire	230	188	165	**-23**	55	37	**+18**	-	-	**-**
Zambia	290	202	149	**-53**	67	47	**+20**	[illegible]	31	**+6**
Zimbabwe	570	86	104	**+18**	94	59	**+35**	12	22	**+10**
MIDDLE EAST and NORTH AFRICA										
Algeria	1830	72	43	**-29**	95	82	**+13**	9	13	**+4**
Egypt	630	55	97	**+42**	91	59	**+32**	9	22	**+13**
Iran	2190	58	39	**-19**	90	86	**+4**	-	-	**-**
Iraq	1500	80	49	**-31**	72	78	**-6**	12	15	**+3**
Jordan	1120	30	60	**+30**	91	72	**+19**	6	17	**+11**
Kuwait	16150	17	12	**-5**	83	96	**-13**	6	3	**-3**
Lebanon	2150	-	-	**-**	-	-	**-**	-	-	**-**
Libya	5310	-	-	**-**	-	-	**-**	-	-	**-**
Morocco	1040	61	63	**+2**	69	70	**-1**	9	18	**+9**
Oman	6490	31	20	**-11**	93	92	**+1**	-	-	**-**
Saudi Arabia	7940	40	18	**-22**	63	92	**-29**	-	-	**-**
Sudan	420	166	125	**-41**	43	50	**-7**	35	26	**-9**
Syria	1160	40	59	**+19**	92	72	**+20**	-	-	**-**
Tunisia	1740	38	45	**+7**	88	81	**+7**	10	15	**+5**
Turkey	1950	87	42	**-45**	98	83	**+15**	-	-	**-**
United Arab Emirates	22220	22	10	**-12**	89	97	**-8**	-	-	**-**
Yemen	520	-	-	**-**	78	55	**+23**	30	24	**-6**
SOUTH ASIA										
Afghanistan	280	-	-	**-**	13	42	**-29**	-	-	**-**
Bangladesh	220	127	168	**+41**	46	35	**+11**	66	34	**-32**
Bhutan	180	201	182	**-19**	12	31	**-19**	38	37	**-1**
India	310	124	145	**+21**	62	40	**+22**	63	30	**-33**
Nepal	170	128	185	**+57**	-	-	**-**	-	-	**-**
Pakistan	410	137	126	**-11**	37	49	**-12**	40	27	**-13**
Sri Lanka	540	19	108	**+89**	95	55	**+40**	29	25	**-4**
EAST ASIA and PACIFIC										
Cambodia	200	-	-	**-**	-	-	**-**	-	-	**-**
China	380	43	131	**+88**	86	46	**+40**	21	31	**+10**

MANCE GAPS

	GNP per capita 1992	Under-five mortality rate 1992			% of children reaching grade 5			% of under-five children underweight		
		Actual	Expected	Difference	Actual	Expected	Difference	Actual	Expected	Difference
Hong Kong	15380	7	12	**+5**	99	95	**+4**	-	-	**-**
Indonesia	670	111	93	**-18**	83	58	**+25**	40	24	**-16**
Korea, Dem	970	-	-	**-**	-	-	**-**	-	-	**-**
Korea, Rep	6790	9	20	**+11**	92	92	**0**	-	-	**-**
Lao Rep	250	145	159	**+14**	-	-	**-**	37	34	**-3**
Malaysia	2790	19	33	**+14**	87	87	**0**	-	-	**-**
Mongolia	780	80	83	**+3**	-	-	**-**	12	20	**+8**
Myanmar	220	113	168	**+55**	-	-	**-**	32	34	**+2**
Papua New Guinea	950	-	-	**-**	67	68	**-1**	35	19	**-16**
Philippines	770	60	84	**+24**	75	64	**+11**	34	20	**-14**
Singapore	15750	7	12	**+5**	100	95	**+5**	14	6	**-8**
Thailand	1840	33	43	**+10**	85	80	**+5**	26	16	**-10**
Viet Nam	240	49	162	**+113**	58	38	**+20**	42	33	**-9**
CENTRAL AMERICA and CARIBBEAN										
Costa Rica	2000	16	41	**+25**	84	84	**0**	6	14	**+8**
Cuba	1170	11	58	**+47**	91	73	**+18**	-	-	**-**
Dominican Rep	1040	50	63	**+13**	41	70	**-29**	10	18	**+8**
El Salvador	1170	63	58	**-5**	45	71	**-26**	15	17	**+2**
Guatemala	980	76	67	**-9**	41	68	**-27**	34	19	**-15**
Haiti	370	133	133	**0**	12	48	**-36**	37	28	**-9**
Honduras	580	58	103	**+45**	41	57	**-16**	21	23	**+2**
Jamaica	1340	14	53	**+39**	96	76	**+20**	7	16	**+9**
Mexico	3470	33	29	**-4**	80	89	**-9**	14	10	**-4**
Nicaragua	410	76	126	**+50**	46	53	**-7**	11	21	**+10**
Panama	2440	20	36	**+16**	82	83	**-1**	16	11	**-5**
Trinidad and Tobago	3940	22	27	**+5**	70	89	**-19**	7	8	**+1**
SOUTH AMERICA										
Argentina	6050	24	21	**-3**	-	-	**-**	-	-	**-**
Bolivia	680	118	92	**-26**	60	60	**0**	13	22	**+9**
Brazil	2770	65	33	**-32**	39	88	**-49**	7	10	**+3**
Chile	2730	18	34	**+16**	85	87	**-2**	3	13	**+10**
Colombia	1290	20	55	**+35**	55	75	**-20**	10	16	**+6**
Ecuador	1070	59	62	**+3**	67	70	**-3**	17	18	**+1**
Paraguay	1340	34	53	**+19**	70	76	**-6**	4	15	**+11**
Peru	950	65	70	**+5**	-	-	**-**	11	18	**+7**
Uruguay	3340	22	30	**+8**	94	88	**+6**	7	10	**+3**
Venezuela	2900	24	33	**+9**	86	88	**-2**	6	11	**+5**
INDUSTRIALIZED COUNTRIES										
Albania	790	40	82	**+42**	97	64	**+33**	-	-	**-**
Australia	17070	9	12	**+3**	99	96	**+3**	-	-	**-**
Austria	22110	9	10	**+1**	100	97	**+3**	-	-	**-**
Belgium	20880	11	11	**0**	81	97	**-16**	-	-	**-**
Bulgaria	1330	20	53	**+33**	79	76	**+3**	-	-	**-**
Canada	20320	8	11	**+3**	96	97	**-1**	-	-	**-**
Czech Rep	2440	12	36	**+24**	96	88	**+8**	-	-	**-**
Denmark	25930	8	9	**+1**	95	98	**-3**	-	-	**-**
Finland	22980	7	10	**+3**	100	97	**+3**	-	-	**-**
France	22300	9	10	**+1**	96	97	**-1**	-	-	**-**
Germany	23030	8	10	**+2**	96	97	**-1**	-	-	**-**
Greece	7180	9	19	**+10**	90	91	**-1**	-	-	**-**
Hungary	3010	16	32	**+16**	97	89	**+8**	-	-	**-**
Ireland	12100	6	14	**+8**	92	94	**-2**	-	-	**-**
Israel	13230	11	14	**+3**	96	95	**+1**	-	-	**-**
Italy	20510	10	11	**+1**	96	97	**-1**	-	-	**-**
Japan	28220	6	9	**+3**	100	98	**+2**	-	-	**-**
Netherlands	20590	7	11	**+4**	95	97	**-2**	-	-	**-**
New Zealand	12060	10	14	**+4**	94	94	**0**	-	-	**-**
Norway	25800	8	9	**+1**	98	98	**0**	-	-	**-**
Poland	1960	16	41	**+25**	99	84	**+15**	-	-	**-**
Portugal	7450	13	19	**+6**	-	-	**-**	-	-	**-**
Romania	1090	28	60	**+32**	96	78	**+18**	-	-	**-**
Slovakia	1920	14	42	**+28**	96	87	**+9**	-	-	**-**
Spain	14020	9	13	**+4**	97	95	**+2**	-	-	**-**
Sweden	26780	7	9	**+2**	100	98	**+2**	-	-	**-**
Switzerland	36230	9	8	**-1**	100	100	**0**	-	-	**-**
United Kingdom	17760	9	12	**+3**	-	-	**-**	-	-	**-**
United States	23120	10	10	**0**	94	97	**-3**	-	-	**-**

* GNP estimated range $676 - $2695

NATIONAL PERFORMANCE GAPS – DERIVING THE EXPECTED

For each of the three indicators used in these tables, deriving an expected level of performance requires the fitting of a line to country data represented by points on a graph of which one axis is always GNP per capita.

When all countries with data are plotted, the pattern that emerges shows that under-five mortality rates and malnutrition rates generally decrease with increasing GNP, whereas the percentage of children reaching grade 5 generally increases with GNP. For each variable, a line was fitted to match the overall shape of the data points, using a least-squares regression method. GNP data for 1992 were used in plotting the graphs except in the case of underweight children, where the data were matched with GNP data for the same reference year.

The adjusted R-squared for the lines thus drawn varied from a little more than 0.4 in the case of the percentage of children underweight to a little over 0.7 for the under-five mortality rate. Such values show that while there is a general trend linking each variable with GNP, many individual countries diverge considerably from this trend.

It is this lack of conformity with the trend line – the expected level of performance – which yields the national performance gaps for each country. The tables on these pages show national performance gaps in bold type.

These pages compare the rate of progress currently being achieved by each country with the rate required if the 90% immunization goal is to be reached.

'On target' denotes countries where the rate required to meet the year 2000 goal is less than the rate currently being achieved. But 'on target' should be interpreted with care. Progress in immunization is not incremental but must begin again from zero with each new generation of infants. Steep falls in coverage are therefore possible if conditions change or if the immunization effort is not maintained (see pages 16 and 17).

RATES OF PROGR

MEASLES IMMUNI

	Measles immunization (%) 1985 actual	1990 actual	1992 actual	2000 goal	Average annual % point increase 1985-1990 actual	1990-1992 actual	1992-2000 required	**Difference between current and required**
SUB-SAHARAN AFRICA								
Guinea	4	18	52	90	2.8	17.0	4.8	**On target**
Namibia	NO DATA	41	63	90	-	11.0	3.4	**On target**
Guinea-Bissau	35	42	60	90	1.4	9.0	3.8	**On target**
Lesotho	73	76	80	90	0.6	2.0	1.3	**On target**
Malawi	53	80	82	90	5.4	1.0	1.0	**On target**
Mauritius	61	84	84	90	4.6	0.0	0.8	**-0.8**
Zimbabwe	53	69	72	90	3.2	1.5	2.3	**-0.8**
Mauritania	59	33	42	90	-5.2	4.5	6.0	**-1.5**
Tanzania	76	83	82	90	1.4	-0.5	1.0	**-1.5**
Chad	7	32	41	90	5.0	4.5	6.1	**-1.6**
Rwanda	52	83	81	90	6.2	-1.0	1.1	**-2.1**
Benin	23	70	70	90	9.4	0.0	2.5	**-2.5**
Niger	27	21	28	90	-1.2	3.5	7.8	**-4.3**
Burundi	36	75	70	90	7.8	-2.5	2.5	**-5.0**
Mozambique	39	58	56	90	3.8	-1.0	4.3	**-5.3**
Uganda	17	74	68	90	11.4	-3.0	2.8	**-5.8**
Angola	44	38	39	90	-1.2	0.5	6.4	**-5.9**
Burkina Faso	18	42	41	90	4.8	-0.5	6.1	**-6.6**
Mali	13	43	41	90	6.0	-1.0	6.1	**-7.1**
Côte d'Ivoire	31	42	40	90	2.2	-1.0	6.3	**-7.3**
Zaire	40	31	31	90	-1.8	0.0	7.4	**-7.4**
Congo	67	75	64	90	1.6	-5.5	3.3	**-8.8**
Nigeria	14	54	45	90	8.0	-4.5	5.6	**-10.1**
Sierra Leone	56	75	61	90	3.8	-7.0	3.6	**-10.6**
Madagascar	28	33	27	90	1.0	-3.0	7.9	**-10.9**
Zambia	49	76	60	90	5.4	-8.0	3.8	**-11.8**
Kenya	63	59	46	90	-0.8	-6.5	5.5	**-12.0**
Senegal	40	59	43	90	3.8	-8.0	5.9	**-13.9**
Botswana	58	78	58	90	2.0	-10.0	4.0	**-14.0**
Ghana	10	60	43	90	10.0	-8.5	5.9	**-14.4**
Liberia	36	55	38	90	3.8	-8.5	6.5	**-15.0**
Cameroon	39	56	37	90	3.4	-9.5	6.6	**-16.1**
Togo	11	57	29	90	9.2	-14.0	7.6	**-21.6**
Ethiopia	12	37	10	90	5.0	-13.5	10.0	**-23.5**
Central African Rep	30	82	32	90	10.4	-25.0	7.3	**-32.3**
Eritrea	NO DATA	NO DATA	NO DATA	90	-	-	-	**-**
Gabon	58	76	NO DATA	90	3.6	-	-	**-**
Somalia	35	30	NO DATA	90	-1.0	-	-	**-**
South Africa	NO DATA	NO DATA	63	90	-	-	3.4	**-**
MIDDLE EAST and NORTH AFRICA								
Iraq	75	62	90	90	-2.6	14.0	0.0	**On target**
Iran	51	83	97	90	6.4	7.0	-0.9	**On target**
Libya	50	70	81	90	4.0	5.5	1.1	**On target**
United Arab Emirates	46	75	85	90	5.8	5.0	0.6	**On target**
Jordan	39	87	91	90	9.6	2.0	-0.1	**On target**
Sudan	6	57	66	90	10.2	4.5	3.0	**On target**
Egypt	74	86	89	90	2.4	1.5	0.1	**On target**
Oman	61	96	97	90	7.0	0.5	-0.9	**On target**
Lebanon	23	39	51	90	3.2	6.0	4.9	**On target**
Morocco	42	79	81	90	7.4	1.0	1.1	**-0.1**
Tunisia	59	87	87	90	5.6	0.0	0.4	**-0.4**
Kuwait	4	98	93	90	18.8	-2.5	-0.4	**-2.1**
Syria	30	87	84	90	11.4	-1.5	0.8	**-2.3**
Saudi Arabia	46	90	85	90	8.8	-2.5	0.6	**-3.1**
Yemen	16	45	46	90	5.8	0.5	5.5	**-5.0**
Turkey	61	78	72	90	3.4	-3.0	2.3	**-5.3**
Algeria	68	83	72	90	3.0	-5.5	2.3	**-7.8**
SOUTH ASIA								
Afghanistan	14	20	42	90	1.2	11.0	6.0	**On target**
Sri Lanka	20	83	83	90	12.6	0.0	0.9	**-0.9**
Pakistan	23	75	76	90	10.4	0.5	1.8	**-1.3**
Bangladesh	3	54	59	90	10.2	2.5	3.9	**-1.4**
India	1	87	85	90	17.2	-1.0	0.6	**-1.6**
Nepal	46	67	64	90	4.2	-1.5	3.3	**-4.8**
Bhutan	27	89	80	90	12.4	-4.5	1.3	**-5.8**

ATION

	Measles immunization (%) 1985 actual	1990 actual	1992 actual	2000 goal	Average annual % point increase 1985-1990 actual	1990-1992 actual	1992-2000 required	Difference between current and required
EAST ASIA and PACIFIC								
Lao Rep	33	13	55	90	-4.0	21.0	4.4	**On target**
Singapore	73	87	92	90	2.8	2.5	-0.3	**On target**
Philippines	55	85	90	90	6.0	2.5	0.0	**On target**
Viet Nam	19	87	90	90	13.6	1.5	0.0	**On target**
Indonesia	47	86	89	90	7.8	1.5	0.1	**On target**
Korea, Rep	89	95	96	90	1.2	0.5	-0.8	**On target**
Mongolia	17	86	88	90	13.8	1.0	0.3	**On target**
Korea, Dem	NO DATA	99	96	90	-	-1.5	-0.8	**-0.7**
China	63	98	94	90	7.0	-2.0	-0.5	**-1.5**
Myanmar	3	73	71	90	14.0	-1.0	2.4	**-3.4**
Thailand	26	80	74	90	10.8	-3.0	2.0	**-5.0**
Malaysia	22	90	79	90	13.6	-5.5	1.4	**-6.9**
Cambodia	29	34	33	90	1.0	-0.5	7.1	**-7.6**
Papua New Guinea	25	67	49	90	8.4	-9.0	5.1	**-14.1**
Hong Kong	85	41	NO DATA	90	-8.8	-	-	**-**
CENTRAL AMERICA and CARIBBEAN								
Trinidad and Tobago	32	70	93	90	7.6	11.5	-0.4	**On target**
Mexico	64	78	91	90	2.8	6.5	-0.1	**On target**
Cuba	85	94	98	90	1.8	2.0	-1.0	**On target**
Honduras	53	90	89	90	7.4	-0.5	0.1	**-0.6**
Costa Rica	81	90	84	90	1.8	-3.0	0.8	**-3.8**
Nicaragua	49	82	72	90	6.6	-5.0	2.3	**-7.3**
Jamaica	64	74	63	90	2.0	-5.5	3.4	**-8.9**
Guatemala	23	68	58	90	9.0	-5.0	4.0	**-9.0**
El Salvador	71	75	62	90	0.8	-6.5	3.5	**-10.0**
Haiti	21	31	24	90	2.0	-3.5	8.3	**-11.8**
Dominican Rep	24	96	75	90	14.4	-10.5	1.9	**-12.4**
Panama	83	99	71	90	3.2	-14.0	2.4	**-16.4**
SOUTH AMERICA								
Bolivia	21	53	80	90	6.4	13.5	1.3	**On target**
Paraguay	46	69	86	90	4.6	8.5	0.5	**On target**
Brazil	63	78	93	90	3.0	7.5	-0.4	**On target**
Peru	53	64	80	90	2.2	8.0	1.3	**On target**
Uruguay	59	82	93	90	4.6	5.5	-0.4	**On target**
Ecuador	54	61	66	90	1.4	2.5	3.0	**-0.5**
Argentina	67	95	89	90	5.6	-3.0	0.1	**-3.1**
Chile	92	98	90	90	1.2	-4.0	0.0	**-4.0**
Venezuela	56	62	61	90	1.2	-0.5	3.6	**-4.1**
Colombia	53	82	74	90	5.8	-4.0	2.0	**-6.0**
INDUSTRIALIZED COUNTRIES								
Germany	NO DATA	50	70	90	-	10.0	2.5	**On target**
Portugal	70	85	95	90	3.0	5.0	-0.6	**On target**
Norway	90	87	94	90	-0.6	3.5	-0.5	**On target**
Israel	85	88	94	90	0.6	3.0	-0.5	**On target**
Finland	87	97	99	90	2.0	1.0	-1.1	**On target**
Hungary	99	99	100	90	0.0	0.5	-1.3	**On target**
Poland	94	95	96	90	0.2	0.5	-0.8	**On target**
France	37	71	76	90	6.8	2.5	1.8	**On target**
Sweden	92	95	95	90	0.6	0.0	-0.6	**On target**
Netherlands	80	94	94	90	2.8	0.0	-0.5	**On target**
Czech Rep	98	99	97	90	0.2	-1.0	-0.9	**-0.1**
Denmark	82	84	85	90	0.4	0.5	0.6	**-0.1**
United Kingdom	62	89	89	90	5.4	0.0	0.1	**-0.1**
Romania	88	92	91	90	0.8	-0.5	-0.1	**-0.4**
Slovakia	98	99	96	90	0.2	-1.5	-0.8	**-0.7**
Ireland	63	78	78	90	3.0	0.0	1.5	**-1.5**
Greece	77	76	76	90	-0.2	0.0	1.8	**-1.8**
Bulgaria	99	98	92	90	-0.2	-3.0	-0.3	**-2.7**
Switzerland	70	90	83	90	4.0	-3.5	0.9	**-4.4**
Albania	96	96	87	90	0.0	-4.5	0.4	**-4.9**
New Zealand	60	90	82	90	6.0	-4.0	1.0	**-5.0**
Italy	12	43	40	90	6.2	-1.5	6.3	**-7.8**
Spain	79	97	83	90	3.6	-7.0	0.9	**-7.9**
Belgium	90	85	67	90	-1.0	-9.0	2.9	**-11.9**
Austria	60	60	38	90	0.0	-11.0	6.5	**-17.5**
United States	NO DATA	NO DATA	77	90	-	-	1.6	**-**

Data for Australia, Canada and Japan not available for the years selected.

THE LAST MILE

In total, 26 of the 87 developing countries listed here are on target to meet the year 2000 goal of immunizing 90% of all infants against measles – provided they maintain the same rate of progress that they have been achieving since 1990.

Of the 61 that are not on target, 36 could achieve the year 2000 immunization goal – if they raised their annual rate of progress to the same level that they achieved in the late 1980s.

These statistics are of course insensitive to the fact that the task of increasing immunization levels tends to grow more difficult as coverage rises. The 20% or more of the world's children who are not immunized today are, by and large, those children who are hardest to reach – the poorest, the most remote, the least educated, and the least well served by health facilities.

But disease also tends to be concentrated – in both frequency and severity – among those who are physically or financially marginalized. So even an immunization rate of 80% means that the job of preventing disease is a job that is only half done.

Maintaining a high enough rate of progress to meet the year 2000 goal of 90% coverage, even in the face of increasing difficulty, is therefore essential if immunization is to fulfil its potential for drastically reducing disease and malnutrition among the children of the developing world.

In 1994, the executive heads of WHO and UNICEF have written to all Heads of State with an appeal for leadership in achieving ten priority social goals by the end of 1995. The letter concludes by saying that the achievement of the 1995 goals would serve as a foundation for achieving the longer-term targets already agreed for the year 2000. These end-of-century goals are summarized in the right-hand column.

The ten goals for 1995 are:

1 The raising of immunization coverage to at least 80%.

2 The elimination of neonatal tetanus.

3 A major reduction in measles deaths and cases.

4 The eradication of polio.

5 The achievement of 80% ORT use to combat diarrhoeal disease.

6 Support for breastfeeding through the 'baby-friendly' hospital initiative and the ending of free and low-cost distribution of breastmilk substitutes.

7 The virtual elimination of vitamin A deficiency.

8 The universal iodization of salt.

9 The virtual elimination of guinea worm disease.

10 The universal ratification of the Convention on the Rights of the Child.

NATIONS OF THE W

STATISTICAL PRO

	Total population (millions) 1992	Population under 16 (millions) 1992	Annual no of births (thousands) 1992	Annual no of under-5 deaths (thousands) 1992	Under-5 mortality rate 1992	GNP per capita ($) 1992	% of under-5 children under-weight	% of children reaching grade 5	Total fertility rate 1992	Maternal mortality rate
SUB-SAHARAN AFRICA										
Angola	9.9	4.9	514	[illegible]	[illegible]	[illegible]	[illegible]	34	[illegible]	[illegible]
Benin	4.9	2.4	243	[illegible]	147	410	[illegible]	[illegible]	[illegible]	160
Botswana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	84	[illegible]	[illegible]
Burkina Faso	9.5	4.4	449	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Burundi	5.8	2.9	271	48	179	[illegible]	[illegible]	[illegible]	6.8	[illegible]
Cameroon	[illegible]	[illegible]	499	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	430
Central African Rep.	[illegible]	[illegible]	142	[illegible]	179	410	[illegible]	41	[illegible]	600
Chad	5.8	[illegible]	258	54	209	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Congo	2.4	[illegible]	107	[illegible]	110	[illegible]	[illegible]	[illegible]	[illegible]	900
Côte d'Ivoire	[illegible]	5.5	650	81	[illegible]	[illegible]	[illegible]	[illegible]	7.4	[illegible]
Eritrea	[illegible]	[illegible]	140	29	208	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Ethiopia	[illegible]	24.0	2487	[illegible]	208	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Gabon	1.2	0.4	53	8	158	4450	[illegible]	[illegible]	[illegible]	190
Ghana	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1000
Guinea	[illegible]	[illegible]	313	72	230	[illegible]	[illegible]	[illegible]	[illegible]	800
Guinea-Bissau	[illegible]	0.4	43	10	239	[illegible]	[illegible]	[illegible]	[illegible]	700
Kenya	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Lesotho	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Liberia	2.8	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Madagascar	12.8	[illegible]	[illegible]	[illegible]	168	[illegible]	[illegible]	34	6.6	570
Malawi	10.4	5.3	567	128	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	400
Mali	9.8	4.8	504	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	2000
Mauritania	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	48	[illegible]	[illegible]	[illegible]
Mauritius	[illegible]	[illegible]	[illegible]	[illegible]	24	[illegible]	24	[illegible]	[illegible]	[illegible]
Mozambique	14.9	[illegible]	683	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Namibia	[illegible]	[illegible]	56	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Niger	8.3	4.1	428	137	320	[illegible]	[illegible]	[illegible]	7.1	700
Nigeria	115.7	57.3	5259	1004	191	[illegible]	[illegible]	[illegible]	6.5	400
Rwanda	7.5	3.9	[illegible]	68	222	[illegible]	[illegible]	[illegible]	8.5	210
Senegal	7.7	3.7	334	48	145	780	[illegible]	[illegible]	6.1	500
Sierra Leone	4.4	2.0	213	53	249	170	29	[illegible]	6.5	450
Somalia	9.2	4.6	469	99	[illegible]	[illegible]	[illegible]	[illegible]	7.0	[illegible]
South Africa	39.8	16.1	1253	88	[illegible]	[illegible]	[illegible]	[illegible]	4.1	[illegible]
Tanzania	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	6.8	340
Togo	3.8	1.8	[illegible]	[illegible]	137	400	24	[illegible]	6.6	420
Uganda	18.7	9.5	[illegible]	178	185	[illegible]	23	[illegible]	7.3	[illegible]
Zaire	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Zambia	8.6	4.4	[illegible]	[illegible]	202	[illegible]	[illegible]	[illegible]	6.4	[illegible]
Zimbabwe	10.6	[illegible]	434	[illegible]	[illegible]	[illegible]	[illegible]	64	5.4	[illegible]
MIDDLE EAST and NORTH AFRICA										
Algeria	26.3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Egypt	54.8	22.5	732	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Iran	61.6	29.7	2473	143	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Iraq	19.3	8.9	753	60	80	[illegible]	[illegible]	[illegible]	[illegible]	120
Jordan	4.3	2.0	171	[illegible]	40	[illegible]	[illegible]	[illegible]	[illegible]	48
Kuwait	2.0	0.8	54	[illegible]	17	[illegible]	[illegible]	93	[illegible]	6
Lebanon	2.8	1.0	78	3	44	2150	[illegible]	[illegible]	[illegible]	–
Libya	4.9	2.3	206	21	104	5310	–	–	6.4	70
Morocco	25.3	11.1	854	52	61	1040	[illegible]	69	4.4	300
Oman	1.6	0.8	67	2	31	6490	[illegible]	[illegible]	6.8	–
Saudi Arabia	15.9	7.1	674	23	40	7940	[illegible]	63	6.4	41
Sudan	26.7	12.6	1128	187	166	420	[illegible]	43	6.1	550
Syria	13.3	6.7	569	23	40	1160	[illegible]	92	[illegible]	140
Tunisia	8.4	3.3	230	9	38	1740	[illegible]	88	[illegible]	50
Turkey	58.4	21.6	1653	144	87	1950	[illegible]	98	3.5	150
United Arab Emirates	[illegible]	0.5	35	1	22	22220	[illegible]	49	4.5	–
Yemen	12.5	6.5	611	108	177	520	[illegible]	[illegible]	7.2	–
SOUTH ASIA										
Afghanistan	19.1	8.2	1031	265	257	280	–	13	6.9	640
Bangladesh	119.3	51.5	4623	587	127	220	66	46	4.8	600
Bhutan	1.6	0.7	65	13	201	180	38	12	5.9	1310
India	879.5	330.8	25900	3212	124	310	63	62	3.9	460
Nepal	20.6	9.4	778	100	128	170	–	–	5.5	830
Pakistan	124.8	57.3	5117	[illegible]	137	410	40	37	6.2	500
Sri Lanka	17.7	6.0	371	7	19	540	29	95	2.5	80
EAST ASIA and PACIFIC										
Cambodia	8.8	3.8	349	64	184	200	–	–	4.5	500
China	1188.0	343.8	25057	1077	43	380	21	86	2.2	95

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ILES

	Total population (millions) 1992	Population under 16 (millions) 1992	Annual no. of births (thousands) 1992	Annual no. of under-5 deaths (thousands) 1992	Under-5 mortality rate 1992	GNP per capita ($) 1992	% of under-5 children under-weight	% of children reaching grade 5	Total fertility rate 1992	Maternal mortality rate
Hong Kong	5.8	1.1	75		7	15380	–	99	1.4	6
Indonesia	191.2	70.5	5146	571	111	670	40	83	3.1	450
Korea, Dem.	22.6	6.9	553	18	33	970	–	–	2.4	41
Korea, Rep.	44.2	11.7	723	7	9	6790	–	92	1.8	26
Lao Rep.	4.5	2.1	205	30	145	250	37	–	6.7	300
Malaysia	18.8	7.5	545	10	19	2790	–	87	3.7	59
Mongolia	2.3	1.1	79	6	80	780	12	–	4.7	140
Myanmar	43.7	17.4	1431	162	113	220	32	–	4.2	460
Papua New Guinea	4.1	1.7	136	11	77	950	35	67	4.9	900
Philippines	65.2	27.0	992	50	50	770	34	75	4.0	100
Singapore	2.8	0.7	44	[illegible]	7	15750	14	100	1.7	10
Thailand	56.1	18.5	1176	39	33	1840	26	85	2.3	50
Viet Nam	69.5	27.9	2039	100	49	240	42	58	3.9	120
CENTRAL AMERICA and CARIBBEAN										
Costa Rica	3.2	1.2	85		16	2000	6	84	3.2	36
Cuba	10.8	2.5	170	2	11	1170	–	91	1.9	39
Dominican Rep.	7.5	2.9	214	11	50	1040	10	41	3.4	–
El Salvador	5.4	2.4	182	11	63	1170	15	45	4.1	–
Guatemala	9.7	4.6	380	29	76	980	34	41	5.4	200
Haiti	6.8	2.9	240	32	133	370	37	12	4.8	340
Honduras	5.5	2.5	205	12	58	580	21	41	5.0	220
Jamaica	2.5	0.8	55	1	14	1340	7	96	2.4	120
Mexico	88.2	34.7	2491	82	33	3470	14	80	3.2	110
Nicaragua	4.0	2.0	163	12	76	410	11	46	5.1	–
Panama	2.5	0.9	63	1	20	2440	16	82	2.9	60
Trinidad and Tobago	1.3	0.5	30	1	22	3940	7	70	2.8	110
SOUTH AMERICA										
Argentina	33.1	10.3	673	16	24	6050	–	–	2.8	140
Bolivia	7.5	3.2	261	31	118	680	13	60	4.6	600
Brazil	154.1	55.2	3626	236	65	2770	7	39	2.8	200
Chile	13.6	4.4	299	4	18	2730	3	85	2.7	67
Colombia	33.4	12.2	809	16	20	1290	10	55	2.7	200
Ecuador	11.1	4.5	332	20	59	1070	17	67	3.7	170
Paraguay	4.5	1.9	[illegible]	[illegible]	34	1340	4	70	4.4	300
Peru	22.5	8.8	658	43	65	950	11	76	3.6	300
Uruguay	3.1	0.8	54	1	22	3340	7	94	2.3	36
Venezuela	20.2	7.8	531	13	24	2900	6	86	3.2	–
INDUSTRIALIZED COUNTRIES										
Albania	3.3	1.1	76	3	40	790	–	97	2.7	–
Australia	17.6	4.1	265	2	9	17070	–	99	1.9	3
Austria	7.8	1.4	91	1	9	22110	–	100	1.5	8
Belgium	10.0	1.9	122	1	11	20880	–	81	1.6	3
Bulgaria	9.0	1.9	111	2	20	1330	–	79	1.8	9
Canada	27.4	6.1	391	3	8	20320	–	96	1.8	5
Czech Rep.	10.4	2.3	135	2	12	2440	–	96	1.9	–
Denmark	5.2	0.9	64	1	8	25930	–	95	1.7	3
Finland	5.0	1.0	64	0	7	22980	–	100	1.8	11
France	57.2	12.3	773	7	9	22300	–	96	1.8	9
Germany	80.3	14.5	912	8	8	23030	–	96	1.5	5
Greece	10.2	2.0	106	1	9	7180	–	90	1.5	5
Hungary	10.5	2.2	127	2	16	3010	–	97	1.8	15
Ireland	3.5	1.0	50	0	6	12100	–	92	2.1	2
Israel	5.1	1.6	110	1	11	13230	–	96	2.9	3
Italy	57.8	10.3	578	6	10	20510	–	96	1.3	4
Japan	124.5	23.7	1390	8	6	28220	–	100	1.7	11
Netherlands	15.2	3.0	207	2	7	20590	–	95	1.7	10
New Zealand	3.5	0.8	60	1	10	12060	–	94	2.1	13
Norway	4.3	0.9	63	0	8	25800	–	98	2.0	3
Poland	38.4	10.1	550	9	16	1960	–	99	2.1	11
Portugal	9.9	2.1	114	2	13	7450	–	–	1.5	10
Romania	23.3	5.7	363	10	28	1090	–	96	2.1	72
Slovakia	5.4	1.4	79	1	14	1920	–	96	2.0	–
Spain	39.1	7.9	422	4	9	14020	–	97	1.4	5
Sweden	8.7	1.7	120	1	7	26780	–	100	2.1	5
Switzerland	6.8	1.2	86	1	9	36230	–	100	1.6	5
United Kingdom	57.7	11.8	801	7	9	17760	–	–	1.9	8
United States	255.2	58.8	4078	42	10	23120	–	94	2.1	8

* GNP estimated range $676 – $2695

The end-of-century goals agreed to by almost all the world's governments following the 1990 World Summit for Children – summarized under ten priority points:

1 A one-third reduction in under-five death rates.

2 A halving of maternal mortality rates.

3 A halving of severe and moderate malnutrition among the world's under-fives, the elimination of micronutrient disorders, support for breast-feeding by all hospitals and maternity units, and a reduction in the incidence of low birth weight to less than 10%.

4 Achievement and maintenance of at least 90% immunization coverage for infants, and universal tetanus immunization for women in the child-bearing years; the eradication of polio, the elimination of neonatal tetanus, a 90% reduction in measles cases, and a 95% reduction in measles deaths (compared to levels before immunization).

5 Achievement of 80% ORT use and a halving of child deaths caused by diarrhoea.

6 A one-third reduction in child deaths from acute respiratory infections.

7 Basic education for all children and completion of primary education by at least 80% – girls as well as boys.

8 Safe water and sanitation for all families.

9 Acceptance and observance, in all countries, of the Convention on the Rights of the Child.

10 Family planning education and services to be made available to all.

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The greying of statistics

The table below gives the average age of the latest internationally available data for three key social indicators – the under-five mortality rate, the percentage of children who reach grade 5, and the percentage of children who are malnourished.

The more up-to-date statistics used by most governments and all international organizations are often interpolated and/or extrapolated from past surveys. The table shows the number of years that have elapsed, on average, between the last national on-the-ground surveys and the year 1993.

In some cases, governments may have more recent statistics that have not yet been made available to the United Nations.

The average age of data has recently been sharply reduced in more than 40 countries selected for DHS surveys.

A small number of countries have no known data at all under certain headings. Published data for such countries usually represent estimates based on neighbouring countries at similar levels of GNP per capita.

Average age (years) of data on three social indicators

SUB-SAHARAN AFRICA

Liberia	13.0	Lesotho	10.3	Rwanda	5.0
Somalia	12.7	Burkina Faso	9.7	Togo	5.0
Central African Rep	12.3	Congo	8.3	Botswana	4.7
Chad	12.3	Côte d'Ivoire	8.3	Senegal	4.7
Benin	12.0	Uganda	7.0	Burundi	4.3
Gabon	12.0	Ethiopia	6.3	Mauritius	3.7
South Africa	12.0	Mauritania	6.3	Nigeria	3.3
Angola	11.7	Kenya	5.7	Tanzania	3.3
Guinea	11.7	Malawi	5.7	Cameroon	3.0
Guinea-Bissau	11.3	Mali	5.7	Zambia	3.0
Mozambique	11.0	Zimbabwe	5.3	Niger	2.7
Zaire	11.0	Ghana	5.0	Namibia	2.3
Sierra Leone	10.7	Madagascar	5.0	Eritrea	-

MIDDLE EAST and NORTH AFRICA

Lebanon*	15.0	Oman	7.7	Algeria	3.7
Libya*	15.0	Sudan	7.7	Iraq	3.0
Iran	8.7	Syria	7.3	Jordan	3.0
Saudi Arabia	8.7	Yemen	7.0	Egypt	2.3
Turkey	8.3	Kuwait	4.3	Morocco	1.7
United Arab Emirates	8.0	Tunisia	4.0		

SOUTH ASIA

Nepal	12.7	India	5.0	Pakistan	3.0
Afghanistan	12.0	Bangladesh	4.3		
Bhutan	7.3	Sri Lanka	3.7		

EAST ASIA and PACIFIC

Cambodia*	15.0	Malaysia	7.7	Thailand	5.0
Korea, Dem*	15.0	Hong Kong	7.3	Indonesia	4.7
Lao Rep	10.0	Mongolia	7.0	Philippines	4.7
Korea, Rep	9.0	Singapore	7.0	Viet Nam	4.3
Papua New Guinea	9.0	Myanmar	6.7	China	4.0

CENTRAL AMERICA and CARIBBEAN

Haiti	9.0	Honduras	5.7	Guatemala	5.0
Nicaragua	7.7	Trinidad and Tobago	5.7	Costa Rica	4.7
Panama	7.3	El Salvador	5.3	Jamaica	4.3
Cuba	6.3	Mexico	5.3	Dominican Rep	3.3

SOUTH AMERICA

Argentina	10.7	Uruguay	5.3	Chile	3.7
Venezuela	6.7	Bolivia	4.3	Paraguay	3.3
Brazil	6.0	Peru	4.3		
Ecuador	5.7	Colombia	4.0		

* Data with an average age of 15 years or more

A note on per capita GNP

The estimates of per capita GNP given in this publication are those calculated by the World Bank by the conventional method using averaged exchange rates to convert local currencies into US dollars.

Alternative estimates, based on purchasing-power parity (PPP), are now becoming available. The advantage of the PPP method is that it measures each nation's per capita income in terms of its local purchasing power rather than by its value on international financial exchanges. It therefore reflects the fact that more can be bought with one dollar in Africa or India than in Europe or North America. PPP estimates are also less vulnerable to exchange rate fluctuations.

But the PPP assessment of incomes entails collecting and correlating a broad range of data on the local pricing of goods and services. So far, this work has been completed in fewer than 70 nations. Estimates for all other countries are based on mathematical models.

For the time being, therefore, *The Progress of Nations* employs per capita GNP figures based on the exchange rate method of conversion.

Abbreviations

ACC/SCN	United Nations Administrative Committee on Coordination/Subcommittee on Nutrition
AIDS	acquired immunodeficiency syndrome
BRAC	Bangladesh Rural Advancement Committee
DHS	Demographic and Health Surveys (IRD/Macro International)
ECPAT	End Child Prostitution in Asian Tourism (Thailand)
FGM	female genital mutilation
GDP	gross domestic product
GNP	gross national product
HIV	human immunodeficiency virus
ICCIDD	International Council for the Control of Iodine Deficiency Disorders
IDD	iodine deficiency disorders
IDWSSD	International Drinking Water Supply and Sanitation Decade, 1981-1990
IRD	Institute for Resource Development (Columbia, Maryland, USA)
MP	Member of Parliament
NAACP	National Association for the Advancement of Colored People
NGO	non-governmental organization
NPA	National Programme of Action
NPG	national performance gap
OECD	Organisation for Economic Co-operation and Development
ORT	oral rehydration therapy
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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